Connecticut Behavioral Health Associates, P. C.

CLIENT INSURANCE INFORMATION

Client Name: _____ Date of Birth: _____

PRIMARY INSURANCE INFORMATION

Subscriber's Name: _____

Subscriber's Date of Birth: _____ Subscriber's Social Security #: _____

Client's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber's Employer: _____ Effective Date: _____

Insurance Company: _____ Insurance Company Phone: _____

Insurance ID#: _____ Group #: _____

SECONDARY INSURANCE INFORMATION

Subscriber's Name: _____

Subscriber's Date of Birth: _____ Subscriber's Social Security #: _____

Client's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber's Employer: _____ Effective Date: _____

Insurance Company: _____ Insurance Company Phone: _____

Insurance ID#: _____ Group #: _____

Bills should be sent to (if other than client):

Name: _____ Relationship to client: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Date of Birth: _____

Email: _____ Social Security #: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

I authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to Connecticut Behavioral Health Associates, P.C. for services rendered to me or my dependent by Connecticut Behavioral Health Associates, P.C.. Should my insurance carrier deny Connecticut Behavioral Health Associates, P.C. payment, I understand that I am financially responsible for the charges.

I authorize Connecticut Behavioral Health Associates, P.C. to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information when any changes occur.

Signature of Client or Authorized Legal Representative: _____ Date: _____