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: __________