young mind center

Insurance Information Form

Client's name:_____ Client's DOB:_____

Name of policy holder: _____Policy holder's DOB:_____

o check if the patient is the policy holder

Policy holder's address:

_____

_____

Policy holder's phone number:_____

Name of insurance carrier:

_____

Provider services phone number:

_____

Insurance billing address:_____

ID:_____Group #:_____

Name of policy holder's employer (if applicable):_____

Group plan name:_____

The Young Mind Center has permission to contact my insurance carrier named above and discuss my coverage and services provided.

_____

Signature of client (or legal guardian) date

o check if verbal consent was given over the phone