1. Insurance ID number	
2. Your last name, first name, middle name	
3. Your birth date (DOB) Your gender	DOB Male Female
4a. Name of the insured person if it is other than you (last, first, middle initial) b. That person's birth date c. Insured person's address	DOB
5. Your address (street, city, state, zip)	
6. Your home telephone number (message okay?) Your cell phone Your business phone	
7. Relationship to the insured person	Self Spouse Child Other
8. Circle all that apply	Single Married Other Employed Full-time Student Part-time student
9. If you are covered by more than one insurance policy, other insured person's name	
9b. That persons policy or group number	
9c. That person's birthday	
9d. Their employers name or name of school	
9e. Insurance plan name (i.e., Blue cross PPO, Magellan EAP)	
10. Circle any that apply—is this related to	Employment injury Auto accident Other accident
11. Primary Insured's (PI) group policy number	
11a. Primary Insured's (PI) birth date (again)	
11b. PI's Employer or school name	
11c. Name of insurance plan	
11d. Do you have another health benefit?	If yes, make sure that 9a-e are complete

I authorize the release of any medical or other information necessary to process this billing claim.

Signature _____ Date _____
I authorize payment of medical benefits to Ruth Parvin, Ph.D.

Signature _____ Date _____

Phone number for your insurance company (for mental health benefits): _____

For office purposes only

Authorization	Deductible	Confirmed with
Co pay	Amount met	Date