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INSURANCE INFORMATION FORM

Please complete the following if you have insurance that I participate in that you would like for me to bill. See my fees policy for information on payment responsibility.

PATIENT INFORMATION

Patient Name _____ Date of Birth _____
First M.I. Last MM / DD / YEAR

Name of Insurance _____ Insurance Phone # _____

Patient Insurance Policy # _____

PRIMARY INSURED INFORMATION

Primary Insured's Name _____ Date of Birth _____
First M.I. Last MM / DD / YEAR

Relationship to Patient _____

Primary Insured Address: _____
Street City State Zip

Primary Insured Policy # _____

Group # _____ Employer _____

I hereby give permission for Dr. Tang to release to my insurance company protected health information required to process claims for services provided. I understand that Dr. Tang is not responsible for how my insurance company uses this information or to whom my insurance company releases this information to. I also understand that I am ultimately responsible for any charges for services rendered that my insurance company denies payment for.

_____ _____
Signature of Patient / Responsible Party Date

_____ _____
Printed Name of Above Relation to Patient

For Office Use Only
Company Contact # _____
Contracted Fee: _____ Patient Co-Pay _____ Deductible _____
Initial Authorization #: _____ # Sessions authorized: _____ Date _____
Max Sessions per Yr _____ Max Paid per Yr _____ Psychological Testing ☐ Yes ☐ No
Notes: _____