Maria Brent, M.A., LPC
COUNSELING AND PSYCHOTHERAPY
215 Highland Avenue, Suite C, Westmont, NJ 08108
Office: 856 854 3155 ext 124 ~ Cell: 856 275 3701 ~ FAX: 856 854 0992

INSURANCE and BILLING INFORMATION

PLEASE BRING YOUR INSURANCE CARD WITH YOU TO FIRST APPOINTMENT

DIRECT BILLING, INC. handles all insurance issues for you and for me. You need to call Kate at Direct Billing before our first appointment if you choose to use insurance. Kate will contact your insurance company for you and give you and me the necessary information. She will help you with all insurance issues. Kate is GREAT! She advocates for you and me.

Call: 800 563 5689

*Please complete this form and bring it to our first meeting. If you bring your insurance card, you have to complete only those items in **BOLD**. You also need to give me permission to bill your insurance and give your insurance permission to pay me. You do this by completing the authorizing statements at the end of this form.*

Name: (include middle initial)_____ DOB_____Age:_____

Phone numbers:_____

Address:_____

Name of the Person Under Whose Policy You Are Insured: _____

DOB:_____ M or F?_____ Your Relationship to Person Insured:_____

Insured Person's Address: _____

Insured Person's Employer: _____

Name of Insurance Company/Insurance Plan Name:_____

Insured Person's Policy Group Number:_____

Insured Person's Identity Number: _____

Your Insurance Identity Number:_____

Effective Date of Insurance:_____ Mental Health Benefits Phone Number:_____

Is There Another Health Benefit Plan/Health Insurance?: Yes_____ No_____

If Yes: Name of the Other Person Under Whose Policy You Are Insured: _____

DOB:_____ M or F?_____ Your Relationship to Other Person Insured:_____

Insured Other Person's Address: _____

Insured Other Person's Employer: _____

Name of Insurance Company/Insurance Plan Name:_____

Insured Other Person's Policy Group Number:_____

Insured Other Person's Identity Number: _____

Your Insurance Identity Number On That Policy:_____

Effective Date of Insurance:_____ Mental Health Benefits Phone Number:_____

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Authorization to Release Health Insurance Information (12)

I authorize the release any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signature:_____ Date:_____

Printed Name: _____

Insured's or Authorized Person's Signature (13)

I authorize payment of medical benefits to Maria Brent, M.A., Licensed Professional Counselor.

Signature: _____ Date: _____

Printed Name: _____