KATY FITZGERALD

Clinical Social Worker/Therapist, LCSW

INSURANCE INFORMATION FORM

Client Name_____ Social Security Number_____ Telephone_____

PRIMARY INSURANCE: Insurance Company_____

Policy ID Number_____ Group Number_____

Policyholder's Name_____ Policyholder's Date of Birth_____

Address_____ City, State, Zip_____

Start Date of Coverage_____ Copay_____ Insurer's Telephone_____

Relationship of patient to policyholder: ☐ Self ☐ Spouse ☐ Dependent ☐ Other ☐ Sex: ☐ M ☐ F ☐ Other

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SECONDARY INSURANCE: Insurance Company _____

Policy ID Number_____ Group Number_____

Policyholder's Name_____ Policyholder's Date of Birth_____

Address_____ City, State, Zip_____

Start Date of Coverage_____ Copay_____ Insurer's Telephone _____

Relationship of patient to policyholder: ☐ Self ☐ Spouse ☐ Dependent ☐ Other ☐ Sex: ☐ M ☐ F ☐ Other

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Consent to Release Information: I authorize any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, peer review organization, insurance or re-insuring company, the Health Care Financing Administration, the Medical Information Bureau, Inc., consumer reporting agency, employer or third party administrator having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my dependents to give the group policyholder, my employer, third party administrator, my third party carrier or its legal representative, any and all such information.

I understand the information obtained by this authorization will be used to determine eligibility for insurance, and eligibility for benefits under my insurance coverage. Any information will not be released except to persons or organizations performing business or legal services in connection with the claim or claims submitted by Katy FitzGerald or as may be otherwise lawfully required or as I may further authorize.

Payment of Benefits: I authorize that payment of medical benefits be made to the physician or organization listed on any claim submitted for any services furnished me by that physician or organization or to an agent contracted by Katy FitzGerald as agent for that physician or organization, as directed by the physician or organization.

I agree that these authorizations shall be valid until rescinded in writing or replaced at a later date.

Client Signature_____ Date_____
(or Legal Guardian if client is a minor)

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