Somatic Psychotherapy

INSURANCE INFORMATION FORM

This form is required for all clients who are covered by insurance, EAP, or managed care benefits.

Client's Name ______________________________ D.O.B. __________ Gender _______________

Address ___________________________ City __________________ State _____ Zip _______

Provide two ways my biller can leave messages for you re: billing/payment matters:

Preferred Method _________________________ Backup Method ____________________________

Would you like to receive statements via email? ☐ Yes ☐ No

Please be aware: Email is not a confidential form of communication. Your email will not be solicited or shared with anyone.

Email Address (if not provided above) ____

Name of Primary Insured ______________________________________ D.O.B. ________________

Relationship of Client to Insured ____

Primary Insured's Employer (if group policy) ____

Employee ID/Policy # of Primary Insured ____________________________ Group # ______________

Check one of the following: ☐ Health Insurance ☐ EAP ☐ Worker's Comp ☐ Automobile Insurance

Are you covered by Oregon Health Plan? ☐ Yes ☐ No

Insurance Company ____

☐ Primary Insurance ☐ Secondary Insurance

Address ___________________________ City __________________ State _____ Zip _______

Telephone No. _____________________________________ Payer ID# If Available ______________

Is there another health benefit plan or insurance company providing coverage? ☐ Yes ☐ No

If Yes, please attach additional pages.

Comments ____

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I hereby authorize Somatic Psychotherapy to provide summary of care and assessment information regarding evaluation and/or treatment of (client's name) __________________________ for the purpose of evaluating and processing claims for benefits. I further authorize payment of medical benefits to Somatic Psychotherapy for services provided.

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Signed Date