# 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 _____

_____

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.

_____ _____

Signed Date

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