Susan Farber, MFT
Embrace Change and Transformation

INSURED/INSURANCE INFORMATION

Insured Name _____ Sex (circle) Female Male

Address _____ Soc. Sec. # _____

_____ Phone # _____

Relationship to client (circle): self spouse child other _____

Insurance Company _____ Insured Date of Birth _____

Address _____ Member I.D. No. _____

_____ Group No. _____

Phone No. _____ Auth No. _____

SECONDARY INSURANCE

Insured Name _____ Sex (Circle) Female Male

Address _____ Member #: _____

_____ Phone #: _____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information. _____ Date _____

I authorize payment of medical benefits to the undersigned therapist for services described on claims. Signature _____ Date _____

I understand that any unpaid balance will be sent to a collections agency, who reports the delinquent account to all three credit agencies:

Signature: _____ Date _____

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