Hillcrest Therapy Center

CLIENT INSURANCE INFORMATION

Client Name: _____

Name of Insured Party: _____Date of Birth:_____

Address of Insured Party if different from client:_____

_____

Insurance Company: _____

Member ID: _____ Group Number:_____

Co-pay Amount: _____ Social Security Number: _____

Other Information: _____

_____

_____

Filing for services is no guarantee of payment. Should your insurance deny the claim for reimbursement, the client is responsible to pay the remainder of the fee for services rendered. When/if that situation arises, you will be billed for the balance. Should your insurance company accept the claim and reimburse our center for services, Hillcrest Therapy Center will not bill you for the difference but will accept whatever your insurance provider reimburses as payment in full.

Client Signature: _____ Date: _____

I do not wish to file insurance.

Client Signature: _____ Date: _____

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