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"Face Sheet" and Health Insurance Claim Information

Patient Name:	First Name	M. Initial	Last Name

Address

City	State	Zip

Home Phone	Work Phone	Cell Phone	eMail (NOT very private – optional)

Social Security # ____ ___ ______	Birth Date: _____ / _____ / _______ mm/dd/yyyy	Sex: ❑ Male ❑ Female

Patient Status:	❑ Single ❑ Married ❑ Other	❑ Employed ❑ Full Time Student ❑ Part Time Student	Condition Related to: ❑ Employment ❑ Auto Accident ❑ Other Kind of Accident?

Referral from:

The bottom of this form can be left blank if you are not going to be using insurance

Insured's ID # Subscriber ID	Insured's Name (If different) (If insured's address or contact information is different, please put it on the back of this sheet.)

Insurance Company Name:	Patient's Relationship to Insured:	❑ Self ❑ Spouse ❑ Child ❑ Other

Insured's Policy Group or FECA Number:

Insured's Birth Date: _____ / _____ / _______ mm/dd/yyyy	Sex: ❑ Male ❑ Female

Employer's Name or School Name:	Insurance Plan Name or Program Name:

Is there another Health Plan Benefit?	❑ No ❑ Yes (Explain) ___________________________

I authorize the **release of any medical or other information necessary** to process health insurance claims.

*Patient's or Authorized Person's Signature:*____

Name:

I authorize **payment of medical benefits** to Lew Mills, PhD, LMFT for services described in claims.

Insured's or Authorized Person's Signature: ____

Name: