Health Insurance Information

Primary Insurance Policy

Insurance Company

Claims Mailing Address

Policy Holder _____ Social Security _____

Date of Birth _____ Relationship to Patient _____

Employer _____

Subscriber Number _____ Group Number _____

Do you know your mental health benefits under this policy? _____

Deductible _____ How much has been met _____

Secondary Insurance Policy

Insurance Company

Policy Holder _____ Social Security _____

Date of Birth _____ Relationship to Patient _____

Employer _____

Subscriber Number _____ Group Number _____

Do you know your mental health benefits under this policy? _____

Deductible _____ How much has been met _____

Do you know your mental health benefits under this policy? _____

Deductible _____ How much has been met _____

Copayment or Co-Insurance

I hereby authorize payment to Psychological and School Services of Eastern Carolina, PLLC, Kelly Moynahan, PhD, LPA, HSP-PA and Secure Medical Collections benefits, if any, otherwise payable to me for her services as documented in my chart but not to exceed the reasonable and customary charge for those services.

I hereby authorize Psychological and School Services of Eastern Carolina, PLLC, Kelly Moynahan, PhD, LPA, HSP-PA and Secure Medical Collections to release my information acquired in the course of my treatment to specific insurance carriers, third party payors, or others involved in processing and collecting of this claim and future claims. Psychological and School Services of Eastern Carolina, PLLC, Kelly Moynahan, PhD, LPA, HSP-PA and Secure Medical Collections is not responsible for the confidentiality of information given to your insurance company or managed care company. I certify that the above questions regarding this application have been answered accurately to the best of my knowledge. I further acknowledge that I am responsible for all charges not covered under my insurance policy.

Signature of Insured _____ Date: _____