SOUTH KITSAP PSYCHOLOGICAL SERVICES

Client Billing Information

I, _____, agree to the release of the following information and any diagnoses to any insurance carrier, managed care association or other third party payer who is responsible for paying or overseeing the payment for psychological services which may be rendered by Jeffrey McCall, Psy.D. This release is valid until the final bill is paid. However, I understand that I may revoke this permission in writing at any time by presenting the revocation and a check for the outstanding balance. Bills submitted by Dr. Jeffrey McCall should be considered approximate until the insurance company has paid, since payment policies vary among companies.

I agree to allow my insurance carrier or other third party payers to pay Dr. McCall directly for the services rendered. Bills to my insurer will reflect this state of agreement.

_____

Client signature Date

Name of Client:_____ Date of Birth_____

Social Security Number: _____

Full Address (including zip code, please) _____

_____

Contact telephone number: _____ Can a message be left? Yes No

Emergency Contact:_____ Telephone number: _____

LABOR AND INDUSTRIES: (if applicable) Case number _____

PRIMARY INSURANCE INFORMATION (must be included if your insurance carrier is billed)

Insurance Company and Address: _____

_____

Name of insured (if different from client) _____ Date of Birth: _____

Social Security number of insured _____

Name, address, and phone number billed under (if different from above)_____

_____

Group Number: _____ Individual Number: _____

Employer _____

Some individuals have secondary insurance carriers, if you do and want them also billed, please fill out the information below. If you **do not have / want** a secondary insurance carrier billed please check the box below and disregard the rest of this form.

☐ I do not have, or I don't want, a secondary insurance carrier billed for these services at this time.

SECONDARY INSURANCE INFORMATION (must be included if your insurance carrier is billed)

Insurance Company and Address: _____

_____

Name of insured (if different from client) _____ Date of Birth: _____

Social Security number of insured _____

Name, address, and phone number billed under (if different from above)_____

_____

Group Number: _____ Individual Number: _____

Employer _____