Monica Rodriguez COUNSELING LLC

PATIENT/INSURANCE/BILLING INFORMATION

PATIENT INFORMATION

Patient Name_____Patient DOB_____

Address_____

Phone_____Alternate Phone_____

Emergency Contact_____Relation to Patient_____

Phone_____Alternate Phone_____

INSURANCE INFORMATION

Primary Insurance_____

Subscriber Name_____

Subscriber DOB_____

Relation to Patient_____

Member ID Number_____

Group Number_____

From back of card:

Plan Phone number_____

Claims Mailing Address_____

_____

Secondary Insurance_____

Subscriber Name_____

Subscriber DOB_____

Relation to Patient_____

Member ID Number_____

Group Number_____

From back of card:

Plan Phone number_____

Claims Mailing Address_____

_____

BILLING INFORMATION

Billing Name_____Relation to Patient_____

Address_____

Phone_____Alternate Phone_____