Teresa McIntyre-Harlow, PhD
Licensed Clinical Psychologist
PSY19632
www.docteresa.com

Client Billing Information

Please fill in the following information as completely as possible. By doing so, we can ensure that your insurance company is billed properly. Thank you.

Patient Last Name _____ First _____ MI _____

If a minor, Parent/Guardian Name _____

Patient's Address _____

City _____ State _____ Zip Code _____ Marital Status _____

Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

Pager/Cell Phone (_____) _____ - _____ E-Mail address _____

Social Security # _____ - _____ - _____ Birth Date _____ / _____ / _____ Sex _____ M _____ F

Employer _____ Occupation _____

Employer's Address _____

Primary Care Physician _____

Primary Insurance Company _____

Ins. Co. Address _____ Phone # (_____) _____ - _____

City _____ State _____ Zip Code _____ I.D./Policy # _____

Group # _____ Name of Insured _____

Birth Date of Insured _____ / _____ / _____ Relationship to Patient _____

Social Security # _____ - _____ - _____ Employer _____

Secondary Insurance Company _____

Ins. Co. Address _____ Phone # (_____) _____ - _____

City _____ State _____ Zip Code _____ I.D./Policy # _____

Group # _____ Name of Insured _____

Birth Date of Insured _____ / _____ / _____ Relationship to Patient _____

Social Security # _____ - _____ - _____ Employer _____

Referral Source _____

I authorize the release of any medical or other information necessary to process insurance claims. I also authorize payment of medical/mental health benefits to Teresa McIntyre-Harlow, PhD for services provided by Teresa McIntyre-Harlow, PhD. I understand that in the event my insurance company does not cover the counseling sessions, I will be held responsible for any monies owed.

Signature of Patient/Authorized Person

_____ Date _____