6046 Cornerstone Ct. W., Suite 130, San Diego, CA 92121
ph: (619) 825-0499; fax: (888) 551-6358
Jennifer@drjennifers.com
www.drjennifers.com
Licensed Psychologist # 22739

Insurance Information

PLEASE CHECK YOUR INSURANCE COMPANY TO CONFIRM THAT I AM IN NETWORK WITH YOUR PANEL AND WHAT YOUR PLAN INCLUDES IN TERMS OF DEDUCTIBLE, COPAYMENTS, NUMBER OF VISITS PER YEAR, ETC. I AM ALSO HAPPY TO CALL FOR YOU TO CONFIRM ALL INFORMATION.

PLEASE NOTE THAT YOU DO, HOWEVER, REMAIN RESPONSIBLE FOR THE CHARGES SHOULD THE INSURANCE COMPANY FAIL TO PAY.

Patient Name____ DOB_____________________

Address _________________________________ ____

Phone _________________________________

Insurance Company Name: ____

Insurance Phone Number ____________________________________

Insurance Address ____ _____________________________________

ID Number ____

Group Number ____ Plan Number _________________________

Subscriber's Name ___________________________________ Rel to Patient __________________________________

Subscriber's Date of Birth _____________________________ Subscriber's SSN _______________________________

Subscriber's Address (if Different From Patient)____

Notes Re: Insurance

_______________________________________ _______________________________________

Signature of Patient or Representative

_______________________________________ _______________________________________

Print Name Date

Rev: 05-31-2011