



**Insurance Information**

Insurance Company Name: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Patient Name (covered by policy): \_\_\_\_\_

Member ID: \_\_\_\_\_

Group ID: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

Mental Health Insurance Company Name  
(if different from above): \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

Annual Deductible: \_\_\_\_\_

Patient Co-Pay: \_\_\_\_\_

How many Therapy Sessions are you allowed per year?

Are there any limitations to your plan?

Are there out of network benefits?

If so, how much does patient get reimbursed per session?