

**Integrated Counseling Center LLC**

Billing Information

**Contact Information**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Maiden Name: \_\_\_\_\_  
Last names used: \_\_\_\_\_ SS# \_\_\_\_\_  
Current address: \_\_\_\_\_ Employer: \_\_\_\_\_  
\_\_\_\_\_  
Guarantor Name (Responsible Payer): \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
  
Address: \_\_\_\_\_ Home telephone number: \_\_\_\_\_  
\_\_\_\_\_  
Employer: \_\_\_\_\_

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Insurance Information

**Primary Insurance**

Name of Insurance: \_\_\_\_\_ Policy holder's name: \_\_\_\_\_  
Policy Holder's SS#: \_\_\_\_\_  
DOB of policy holder: \_\_\_\_\_  
Carrier Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
Customer Service Number: \_\_\_\_\_  
ID (subscriber) Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Prior Authorization Number: \_\_\_\_\_

**Secondary Insurance**

Name of Insurance: \_\_\_\_\_ Policy holder's name: \_\_\_\_\_  
Policy Holder's SS#: \_\_\_\_\_  
DOB of policy holder: \_\_\_\_\_  
Carrier Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
Customer Service Number: \_\_\_\_\_  
ID (subscriber) Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Prior Authorization Number: \_\_\_\_\_

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**Office Use Only**

Effective dates: \_\_\_\_\_  
Deductible: In Network \_\_\_\_\_ Out of Network \_\_\_\_\_  
Met Yes/No Amount Owed \_\_\_\_\_ Met Yes/No Amount Owed \_\_\_\_\_  
Copayment/Coinsurance: In Network \_\_\_\_\_ Out of Network \_\_\_\_\_  
Annual Maximum: \_\_\_\_\_ (number of visits or dollar amount)  
  
Prior Authorization Required Authorized Y \_\_\_\_\_ N \_\_\_\_\_