Colleen Parker, Ph.D.
Billing Information Form

Patient Information - Please print clearly.

Patient Name: _____ DOB: _____

Gender: M F Marital Status: _____ SSN: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cellular: _____ Email: _____

May messages be left for you at home? _____ At work? _____ Cell? _____ Email? _____

Insurance Information - Please provide a copy of your insurance card(s), front and back, or bring your card(s) to your first appointment so that copies can be made.

Primary Insurance Carrier: _____ Phone: _____

Claims Address: _____ City: _____ Zip: _____

Name of Insured: _____ Relation to Patient: _____

Insured ID Number: _____ Group Number: _____

Insured DOB: _____ Phone: _____ Employer: _____

Insured's Address: _____ City: _____ Zip: _____

Secondary Insurance Carrier: _____ Phone: _____

Claims Address: _____ City: _____ Zip: _____

Name of Insured: _____ Relation to Patient: _____

Insured ID Number: _____ Group Number: _____

Insured DOB: _____ Phone: _____ Employer: _____

Insured's Address: _____ City: _____ Zip: _____

I hereby authorize the release of all medical information necessary to process an insurance claim. I hereby authorize my insurance carrier to make payments directly to Colleen Parker, Ph.D. I understand that I am financially responsible for all charges, regardless of insurance, unless otherwise written by Colleen Parker, Ph.D. I understand the financial policy established by Colleen Parker, Ph.D. I understand that balances left unpaid over 90 days from the date of service may be assessed a 1.5% rebilling / past due account fee (minimum $5.00) per month and / or may be referred to a collection agency to facilitate payment.

_____ Date: _____