Denise Reynolds, Psy.D.
www.drdenisereynolds.com **(512) 423-0808**

Please provide the following information if you plan to use insurance

Client Name_____

Client Address_____

Client Phone Number_____

Client Date of Birth _____ Client SSN: _____

Policy Holder's Identification #: _____ Group #: _____

Policy Holder's Relationship to Client_____

If different from client information, please complete the following:

Policy Holder's Name_____

Policy Holder's Date of Birth_____ Policy Holder's SSN:_____

Policy Holder's Address_____

Policy Holder's Phone Number_____

Everyone must complete the following:

- I authorize the release of any clinical or other information necessary to process my insurance claim. YES / NO (circle one)
- I authorize payment of insurance benefits to the provider, Denise Reynolds, Psy.D. YES / NO (circle one)

Name of Mental Health Insurance _____

Preauthorization or certification number (if required)_____

Do you have any secondary insurance? YES / NO (circle one)
If yes, please provide secondary insurance company name, billing address, and phone number

_____

_____

Insured or Client's Signature _____