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 ________________________

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 Address____

Policy Holder's Phone Number____

<u>Everyone must complete the following:</u>

- 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 ____