Nathan J. Miles, PhD
Counseling & Psychological Services

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Insurance Information

Primary Insurance

Plan name: _____

Name of subscriber: _____
Last name, First name MI

Policy ID: _____ Group ID: _____

Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Address: _____
Address City, State Zip

Subscriber's date of birth: ____/____/____ Phone number: ( ) _____

Provider services number (on back of card): ( ) _____

Secondary Insurance

Plan name: _____

Name of subscriber: _____
Last name, First name MI

Policy ID: _____ Group ID: _____

****** Your Co-Pay is Due at the Time of Service ******

By signing below, you acknowledge that Nathan J. Miles, PhD will contact your insurance company or companies in order to bill for services provided. Data that will be transmitted include - but are not limited to - diagnoses, dates of services provided, type of services provided, and cost of services provided. Additionally, should the insurance company or companies request therapy records, I will comply.

_____ _____
Signature Date