Jayna Klatzker, LICSW
1 Richmond Square, Suite 132C
Providence, RI 02906
401-297-2021

INSURANCE INFORMATION: **Date:_____**

Patient name as listed with Insurance:

Last_____ MI_____ First_____

Address _____

City _____ State _____ Zip Code _____

Date of Birth _____ Gender Listed _____

Phone Contact Number _____

Email _____

RESPONSIBLE PARTY/POLICY HOLDER Check here if Responsible Party is same as Client ___

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Phone Contact _____ Relationship _____

Email _____

PRIMARY INSURANCE COMPANY:

Insurer: BCBSRI: ____ United Behavioral Health:___ Other:_____

Usually listed on the back of your card:

Providers/Claims Phone: _____

Please be familiar with your policy!

Co-Pay: _____ Referral needed? Call your Doctor Number of sessions _____
Deductible Amount _____

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other

Insured's I.D. Number _____
Insured's Policy Group Number _____
Insured's Date of Birth _____/_____/_____ Gender listed □ Male □ Female

Insured's Employer's Name _____
Insured's Plan Name _____

SECONDARY INSURANCE COMPANY:

Insured's Name (First, Middle Last) _____
Address:_____
Client Relationship to Insured □ Self □ Spouse □ Child □ Other
Insured's I.D. Number _____ Social Security # _____-_____-_____
Insurance Company _____

If your insurance company rejects claims, attempts will be made to remedy the situation.

However, you, as the consumer of these services, have the responsibility to pay for services rendered.

_____ _____ _____
Print (Parent or Guardian if client is a minor) Signature Date

_____ _____ _____
Print (Responsible Party if different from above) Signature Date

_____ _____ _____