HEART | MIND
THERAPY

INSURANCE INFORMATION

Client information

Client Name: DOB: / /
Primary Insurance Company:
Insurance ID #:
Group #:
Copay: $
Deductible: $
Has your deductible been met?
If not, how much is left?: $

Subscriber Information (Please complete if other than client)

Relationship to client:
Subscriber's Name:
Subscriber's Date of Birth: / /
Subscriber's Address:
City: State: Zip:
Subscriber's Phone number:
Subscriber's Employer:

Notice:

I understand that if Dr. Jana Corbett is in-network with my insurance company, she will collect my deductible or co-pay and bill my insurance company. I understand that I am responsible for tracking my benefits, prior treatment authorizations and eligibility. I understand that I need to inform Dr. Jana Corbett immediately if my benefits change. I understand that I am responsible for any charges not covered by my insurance company.

I have read this and understand it. (You may sign electronically through the patient portal.)

Client signature:_______________________________________ Date: _________________