1919 Middle Country Road, Suite 308
Centereach, NY 11720
www.cbtsolutionsli.com
631-209-5343

INSURANCE/BILLING INFORMATION

Insurance Carrier: ____

ID#: ____

Group #: ____

Name of Policy Holder: ____

D.O.B.: ____

Sex: M F

Address: ____
City: ____
State: ____
Zip: ____

Relationship of Policy Holder to Patient: SELF SPOUSE PARENT OTHER

I UNDERSTAND THAT I AM RESPONSIBLE FOR THE PAYMENT OF ALL CO-PAYMENTS AND DEDUCTIBLE AMOUNTS FOR SERVICES I RECEIVE. ALL CO-PAYMENTS ARE DUE AT THE END OF EACH TREATMENT SESSION. I AGREE THAT I AM RESPONSIBLE FOR ANY FEES INCURRED AT THIS OFFICE SHOULD MY INSURANCE CARRIER FAIL TO PAY FOR TREAMENT SERVICES THAT I RECEIVE.

Patient/Parent/Guardian Name: ____________________________________
(Please Print)

Signature:____