

Aimee Zakrewski Clark: AZ GROWTH

11777 Sorrento Valley Road, Suite 220 • San Diego, CA 92121 (760) 803-3600

HEALTH INSURANCE AGREEMENT FORM

INSURANCE INFORMATION:

Health Plan/Insurance: _____ Policy # _____

Subscriber Name: _____ SSN # _____ DOB _____

Employer: _____

Referred by: _____ (Physician Name if applicable)

Financial Terms with Health Insurance:

Many clients have insurance coverage for psychotherapy services. As with all health care, the client or designated party is responsible for payment of services. Insurance forms will be prepared on a monthly basis to help collect from insurance carriers when the forms and information required by the insurance company are submitted to this office.

_____ of AZ Growth is:

_____ In-Network Provider _____ Out-of-Network Provider

Out-of-Network: Fee shall be paid in full by the client each session. Insurance forms will be prepared on a monthly basis. _____ of AZ Growth deems no responsibility for the reimbursement of payment from the client's insurance carrier. It is the responsibility of the client to send in the forms and receive reimbursement from their insurance carrier.

Your fee per visit is \$ _____.

Client (or Parent/Guardian) Print

Client (or Parent/Guardian)
Signature

Date

Client (or Parent/Guardian) Print

Client (or Parent/Guardian)
Signature

Date

Provider Print

Provider Signature

Date

