Kristy Kirby, LMFT #48653

419 Mason Street, Ste. 212 · Vacaville, CA 95688 · 707-365-9246

Insurance Billing Information

Please Bring a Copy of Your Card to Your First Session

Date ___________________________

Client Name: ____ DOB: ___________________

Client SSN: ____

Insured's Name _____________________________ Insured's SSN ____________________________

Insured's ID # ___________________________________ Group # ____________________________

Insurance Plan or Program Name: ____

Insured's Date of Birth: _________________________ Gender: Male/Female

Insured's Address: ____

Employer's Name: ____

Phone Number on back of card for Behavioral Health: ____________________________________

Client's relationship to insured: ☐Self ☐ Spouse ☐ Child ☐ Other: ______________

Client's marital status: ☐married ☐single ☐other: ____________________

Client's job status: ☐ employed ☐ full-time student ☐ part-time student

I authorize payment to Kristy Kirby, LMFT for services rendered. I also authorize Kristy Kirby, LMFT to provide information required for third party billing on my behalf. This may include, but is not limited to, Diagnosis, Treatment Plans and authorizations required for reimbursement. **I understand that every effort will be made for insurance reimbursement, however if my claim is denied by my insurer, I bear the full financial responsibility for services received.**

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Insured or Authorized Person's Signature Date

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Print Name