Insurance Information Agreement **J. Elana Breiner, LMFT**

Please fill out the following information only if you wish to use your insurance to pay for your therapy, and have verified with my office that I am a participating provider.

Name of Primary Insurance: _____ Phone: _____

Group Name or #: _____Member ID #: _____

Policy Holder's Name (If Different from Client): _____

Policy Holder ID #: _____Policy Holder Birth Date: _____

Address: _____

Relation to Client: _____ Authorization #: _____

Do you have an EAP? **No** **Yes**

Do you have any other insurance? **No** **Yes** **If yes, please notify the office manager.**

Please read and sign the following.

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to J. Elana Breiner. I also request payment of government benefits either to myself or to the party who accepts assignment as indicated on the insurance claim form.

Signature: _____ Date: _____