1924 Route 35, Suite 9A
Wall, NJ 07719
(732) 359-8686

Insurance Information

Insurance Company Name: ____

Policy/ID Number:________________________Group#: ________________

Subscriber's Name:______________________Relation to Client: __________________

Subscriber's DOB:____________________Phone #: ____________________________

Subscriber's Address: ____

Subscriber's Employer: ____

Payment Policy

I will submit your claim on your behalf. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. I am not a party to that contract.

Missed Appointments

My policy is to charge for missed appointments not cancelled within 24 hours. These charges will be your responsibility and billed directly to you.

Client Authorization

- By signing below, I hereby assign all insurance benefits to which I am entitled to Phoebe Jeffrey, LPC, LLC. I authorize Phoebe Jeffrey to release to the Health Care Financing Administration, its agents or to other insurance company any information that is in the record and is necessary to secure payment.
- I authorize my insurance benefits to be paid directly to Phoebe Jeffrey LPC, LLC. I am financially responsible for any deductible, copayments and non-covered services.
- I acknowledge that I was provided a copy of the Notice of Privacy Practices.
- I have read and agreed to the above statements.

Signature:______________________________________Date: ______________________

Signature of Responsible Party or Guardian ______________________________________

Relation to Minor Client: ____