Christopher Greene, LCSW
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Guilford, CT 06437
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Website: www.christophergreene.com

INSURANCE INFORMATION

INFORMATION ABOUT THE PATIENT

Patient's Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Patient's Birth Date: _____

Patient's Marital Status: (Check One): Single: ☐ Married: ☐

Is the Patients condition related to (Check all that apply): Employment: ☐

Auto Accident: ☐

Other Accident: ☐

INFORMATION ABOUT THE PERSON WHO IS INSURED

Insured Person's Name: _____

Insured Person's Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Insured's Birth Date: _____

Insured's I.D. Number: _____

Insured's Policy, Group or FECA Number: _____

Name of Insured's Insurance Plan or Program: _____

Address of Insured's Insurance Plan: _____

_____

_____

Name of Insured's Employer or School: _____

Is the Patient covered by any other Health Benefit Plan? Yes: ☐ No: ☐

INFORMATION ABOUT THE 2ND INSURED PERSON

2ND Insured Person's Name: _____

2ND Insured Person's Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Insured's Birth Date: _____

Insured's I.D. Number: _____

Insured's Policy, Group or FECA Number: _____

Name of Insured's Insurance Plan or Program: _____

Address of Insured's Insurance Plan: _____

_____

_____

Name of Insured's Employer or School: _____

To Be Signed by the Patient.

I authorize the release of any medical or other information necessary to process health insurance claims related to my treatment with Christopher Greene, LCSW.

Signature: _____ Date: _____

To be signed by the 1st Insured.

I authorize payment of medical benefits to Christopher Greene, LCSW for services rendered.

Signature: _____ Date: _____

To be signed by the 2nd Insured.

I authorize payment of medical benefits to Christopher Greene, LCSW for services rendered.

Signature: _____ Date: _____