

PBJ Connections Provider: _____

Diagnosis _____

Please complete with Name as it appears on Insurance Card

Client Last Name _____ First Name _____ MI ____ DOB ____/____/____
Gender: M F Other SSN: _____ Marital Status: Married Single
Home Street _____ City _____ State ____ Zip _____
Home Phone (____)-____-____ Cell (____)-____-____ Work (____)-____-____ EX _____
Email: _____

PRIMARY INSURANCE INFORMATION: Must be completed to bill your Insurance

Insurance Name: _____ Plan Name: _____
Address: _____ Deductible _____ Visit co-pay _____
Subscriber ID: _____ Group No: _____
Clients Relationship to Primary Insured: (required circle one) Self Spouse Child Other

If client is not the policy holder, please complete the section below:

Policy Holder Name: _____ MI ____ DOB ____/____/____
SSN: _____ Marital Status: Married Single
Policy Holder Address: _____ City _____ State ____
Zip _____ Phone (____)-____-____ Email: _____

Insurance Authorization No: _____ Number of Authorized Sessions: _____
Authorization Start Date: ____/____/____ Authorization Stop Date: ____/____/____

Secondary Insurance

Policy Holder Name: _____ MI ____ DOB ____/____/____
SSN: _____ Relationship to client _____
Insurance Name _____ Plan Name: _____
Address: _____
Subscriber ID: _____ Group No: _____

GreenPointMed will bill your insurer directly for all services utilizing the HIPAA compliant system, *Therapy Notes*. Your signature expresses your agreement that the dates of service, services rendered, and diagnosis will be provided to GreenPointMed for billing purposes only. The client's or responsible person's signature below authorizes release of any medical information requested by the insurer in order to process insurance claims and authorizes payment of medical benefits to be made directly to the supplier of services.

Signature _____ **Date** _____