Insurance & Billing Information – Tashia Amstislavski, MA, LCSW, LLC

Name:_____ Date:_____

Date of birth:_____ Gender: M_____F_____Soc Sec #:_____

Address:_____
City_____ State_____Zip:_____

Home phone:_____Work #:_____ Cell #:_____

Email:_____

Medical insurance company:_____
If covered through employer/group, name of employer/group:_____
Insurance ID#:_____ Plan name:_____

Group #:_____Group name:_____

If policy holder is other than patient, name:_____
Relationship to patient:_____Date of birth:_____ Gender: M____F____

Address (if different than patient):_____
City_____ State_____Zip:_____

Home phone:_____Work #:_____Cell #:_____
Email:_____

May we contact this person if we have questions about this insurance? Y_____N_____

Secondary insurance company:_____
If covered through employer/group, name of employer/group:_____
Insurance ID#:_____ Plan name:_____

Group #:_____Group name:_____

If secondary policy holder is other than patient, name:_____
Relationship to patient:_____Date of birth:_____ Gender: M____F____

Address (if different than patient):_____
City_____ State_____Zip:_____

Home phone:_____Work #:_____Cell #:_____
Email:_____

May we contact this person if we have questions about this insurance? Y_____N_____

By signing below:

- I authorize the release of any medical or other information necessary to process my insurance claims.
- I authorize payment of my government and/or private insurance benefits directly to Tashia Amstislavski, MA, LCSW.
- I understand that Tashia Amstislavski, MA, LCSW offers insurance billing as a courtesy; I assume responsibility for

all charges, and agree to pay any denied claims, non-covered charges, deductibles and copayments, and any fees excessively delayed or otherwise not reimbursed by my insurance carrier for any reason.

- All copayments are due at the time of service. If you are unsure of your co-pay amount, you will be charged a co-pay of $30.00 until that amount is determined.

****Please bring all insurance cards along with this form to your first appointment.****

_____ _____

Signature Date