Nancy T. McCarel, Ph.D., BCB
987 Old Eagle School Rd., Ste. 719
Wayne, PA 19087
610-971-2277

Patient Information:

Name_____

Address_____

Home phone_____ Birthdate_____

Cell Phone_____ Referred by: _____

Insurance Subscriber Information:

Name_____

Relationship_____ Birthdate_____

Phone number for Ins. Co._____Insurance Type_____

ID Number_____ Group Number_____

Coverage Information (for office use only)

In Network:	**Out of Network:**
Deductible amount_____	_____
Copay Pt._____	_____
Copay Ins._____	_____
Visits/yr._____	_____
Pre-cert?_____	_____

I authorize the release of information necessary to process health benefit claims. If there is a copayment, it will be established upon receipt of explanation of benefits from the primary insurance company, as well as any supplemental insurance, and I will be responsible for it. Additionally, if my insurance coverage changes or benefits run out and sessions are no longer covered, I understand that I am responsible for payment of the full fee.

Signed _____

Date _____