



**PATIENT UPDATE OF INFORMATION**

Date: \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Ph.# \_\_\_\_\_ Cell Ph.# \_\_\_\_\_

Work Ph.# \_\_\_\_\_ Other Ph.# \_\_\_\_\_

Email: \_\_\_\_\_

We'd love to keep you informed of any upcoming events, community resources and workshops as well as exclusive articles from our skilled clinicians. May we add you to our CGCC email database?  
 \_\_\_ Yes! \_\_\_ No, thank you.

**Insurance Information**

Primary Insurance Name: \_\_\_\_\_

Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_

SS# \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Phone# \_\_\_\_\_

Policy ID#: \_\_\_\_\_

Group: \_\_\_\_\_

VERIFICATION OF INSURANCE BENEFITS VERIFIED ON: \_\_\_\_\_ Ref# \_\_\_\_\_

What to collect from pt.:		IN NETWORK		OUT OF NETWORK	
<b>1<sup>st</sup> Visit:</b> _____	Individual Deductible	\$ _____	Met: \$ _____	\$ _____	Met: \$ _____
<b>Then:</b> _____	Family Deductible	\$ _____	Met: \$ _____	\$ _____	Met: \$ _____
<b>Until Deductible met, then</b>	Copay/ Co-ins				
<b>Collect:</b> _____	Indv. Out of Pocket	\$ _____	Met: \$ _____	\$ _____	Met: \$ _____
	Fam. Out of Pocket	\$ _____	Met: \$ _____	\$ _____	Met: \$ _____

Pre-authorization required? Y\_\_ N\_\_ Auth# \_\_\_\_\_ for # of Visits: \_\_\_\_\_

EAP or Non-EAP? \_\_\_\_\_ CPT code? \_\_\_\_\_ Effective: \_\_\_\_\_ Expires: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_