CORAL GABLES Counseling CENTER

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.:

1st Visit: _____

Then: _____

Until Deductible met, then Collect: _____

	IN NETWORK		OUT OF NETWORK	
Individual Deductible	$	Met: $	$	Met: $
Family Deductible	$	Met: $	$	Met: $
Copay/ Co-ins				
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: _____

_____