Bonnie Rumble, MFT

PERSONAL INFORMATION

Name:_____ Age:_____
Last, First MI

Street Address:_____

City:_____ State:_____ Zip:_____

Phone: (____)_____ Cell: (____)_____ Pager: (____)_____

DOB____/____/_____ Male/Female SS#_____ Marital Status:_____

Employer_____ Work Phone: (____)_____

RESPONSIBLE PARTY INFORMATION (person financially responsible to pay for deductible & co-pays)

Name:_____ Age:_____
Last, First MI

Street Address:_____

City:_____ State:_____ Zip:_____

Phone: (____)_____ Cell: (____)_____ Pager: (____)_____

DOB____/____/_____ M / F SS#_____ Marital Status:_____

Employer_____ Work Phone: (____)_____

INSURANCE INFORMATION - Insurance Prior Authorization Number: (see note below)_____

Primary Ins:_____ Phone # for mental health: (___)_____

Subscriber name:_____ SS#_____ DOB___/___/_____

Employer_____ Work Phone: (____)_____

Relation to client:_____ ID/Membership #:_____ Group #:_____

Secondary Ins:_____ Phone # for mental health: (___)_____

Subscriber name:_____ SS#_____ DOB___/___/_____

Employer_____ Work Phone: (____)_____

Relation to client:_____ ID/Membership #:_____ Group #:_____

REFERRED BY:_____

In addition to filling this form out, please scan or take a picture of the front and back of your insurance card(s) and fax them to me with this form. Fax: 760-919-3132
Emailing them is not recommended.

I hereby authorize Bonnie Rumble, MFT to release any information requested by Reliable MH Billing Services that is needed to bill the above named insurance companies and/or responsible party directly. I hereby authorize Bonnie Rumble, MFT & Reliable MH Billing Services to release any information requested by the above named insurance companies that is needed for claim processing, and to pay directly to Bonnie Rumble, MFT any insurance benefits.

***NOTE:** I understand that I may need prior authorization from my insurance company to see Bonnie Rumble, MFT and that it is my responsibility to get the authorization prior to, or on the day of my first appointment. If authorization is required by my insurance company and I do not obtain it, I understand that I am financially responsible for the services not covered by my insurance company. Furthermore, I understand that I am financially responsible for the services with Bonnie Rumble, MFT should my insurance company deny my claims submitted by Reliable MH Billing Services.*

I affirm the above to be true, and give my consent for treatment.

_____ _____
Signature Date

PLEASE PRINT NEATLY OR FILL OUT ON THE COMPUTER. THANK YOU.