FOR OFFICE USE ONLY:

DX: _____
Co-Pay _____
Deductible: _____
Deductible met _____
Authorization # _____
# of Sessions: _____
Visits per Year _____
Verify Ins. _____
% Insurance pays _____
Effective date: _____
Ins. Company: _____
Ins. Phone #: _____

Danute Kuncas, LCPC.
Somatic Psychotherapy
210 W. 22nd Street, Suite 118
Oakbrook, IL 60523

www.danutekuncas.com
danute2015@gmail.com
630.926.6849

Patient Information:

Last Name:_____First Name:_____M.I:_____

Address:_____

City:_____State:_____Zip code:_____

Date of Birth:_____Sex:_____Social Security #:_____

Phone:_____E-mail:_____

Policyholder's Information:

Last Name:_____First Name:_____M.I._____

Date of Birth:_____Sex:_____Social Security #:_____

Home Phone:_____Work Phone:_____

Insurance Information:

Primary Ins. Co Name:_____Group #:_____Phone:_____

Address:_____

Policyholder's Name: _____ID#:_____

Secondary Ins. Co Name:_____Group #:_____Phone:_____

Address:_____

Policyholder's Name:_____ID#:_____

CONSENT, ASSIGNMENT AND RELEASE: I hereby consent to treatment. I hereby assign my insurance benefits to be paid directly to the above provider. I am financially responsible for non-covered services. Assignment of benefits does not release the undersigned from responsibility of payment. I authorize the therapist to release any information required to process this claim. This authorization and consent shall remain in effect until such time as it is revoked by me.

PATIENT SIGNATURE:_____ DATE:_____