Lynda Green-Alter, LMFT
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Phone: (949) 453-9600 FAX: (949) 453-9601

P A T I E N T: _____

SECONDARY I N S U R A N C E

Name of Insured: _____ Relationship to Patient: _____

Insured's Soc. Sec. #: _____ Insured's Date of Birth: _____

Insured's Address: _____ City: _____ Zip: _____

Insured's Employer: _____

Employer's Address: _____ City: _____ Zip: _____

Insurance Company: _____ Phone #: (_____) _____

Insurance Company's Address for Claims: _____ City: _____ State: ___ Zip: _____

Policy #: _____ Group #: _____

AUTHORIZATION (Signature on File)

I authorize use of this form on all my insurance claim submissions. I authorize the release of any medical or other information necessary to process my insurance claims. I understand that **I am responsible** for my bill.

For any schedule appointments that I do not show up OR I cancel with less than 24 hours prior notice, I acknowledge that I will be charged and will be personally responsible for a **$175** charge.

I authorize **Lynda Green-Alter, LMFT** to act as **my** agent in helping to obtain payment from my insurance carrier(s). I irrevocably authorize payment of medical benefits directly to **Lynda Green-Alter, LMFT** for services rendered to me. I request payment of government benefits be made directly to **Lynda Green-Alter, LMFT**, who hereby accepts such assignment. I permit a copy of this authorization to be used in place of the original.

Dated: _____ Signature: _____

Print Name: _____