Arlene C. Gerson, PhD
Clinical Psychologist
9650 Santiago Road, Suite 3
Columbia, MD 21045

Patient Insurance Information

As a service to you, I will bill CareFirst Blue Cross/Blue Shield of Maryland. The person responsible for the payment of the account is financially responsible for paying the amount not paid by insurance after 60 days. Payments not received after 120 days are subject to collections. Insurance deductibles and co-payments are due at the time of service.

Please feel free to address any questions regarding my financial policies during the initial interview or when they arise.

Insurance Company Name: ____________________Insurance Phone #:___________________

Patient's Membership #: _______________________ Group # or enrollment code:_________________

Patient DOB: ___________________

Patient Street Address: ____________________________________________________________________

City_____________________State_______ Zipcode ________________

**Policy Holder Information**:

Name:___________________________________________________ DOB:_______________________

Insured's Employer: ____________________________________________________________________

Relationship to Patient:______________________________________

Did you call your insurance company prior to today's appointment? YES NO
What is your yearly deductible? _____________________ What is your Co-Pay? ________________

I authorize the release of any medical information necessary to process the insurance claim. I agree that full payment for services will be made by me regardless of insurance coverage.

Signature of Policy Holder: _______________________________ Date:_________________________