Therapeutic Time Inc.

Insurance Release

Patient's Name ________________ ________________ ________
Last First M.I.

SS# ______________ Date of Birth ___/___/___ Sex: M/F Marital Status ___

Home Address ______________________________ Apt# ________

______________ ______________ ______________
City State Zip Code

Home # ____________ Work # ____________ Cell # ____________

Email address: ______________________________

Primary Insurance Information

Policyholder Name ______________ Date of Birth ___/___/___ SS# ______________

Insurance Name ______________________________

Policy# ______________________ Group# ______________

Relationship to Policyholder: Self_____ Spouse_____ Child_____ Other_____

__ Employer Name ______________________________

Address ______________ City ______________ State ________ Zip ____________

Name of emergency contact ______________ Phone ____________ Relationship ____________

A quote of benefits is not a guarantee of payment unless otherwise required by law. All benefits are subject to the terms, conditions, limitations and exclusions under the members policy, including the patient's effective status on the actual date of service. Final determination will be made once the claim has been received and processed.

I give permission to share with my insurance company any information they might need to complete processing of claims submitted on my behalf. I authorize my insurance company to send all benefits directly to the provider.

All appointment cancellations must be made 24 hours before the time of appointment. No notice within 24 hours or no attendance of the session can result in a fee equal to the provider's usual and customary rate.

X ______________________________ Date ______________

Patient signature or guardian for the minor patient

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