3040 N. University Ave. Suite 2
Decatur, IL 62526
phone: 217.872.1700
fax: 217.872.1366
www.decaturpsych.com

Insurance Information

Method of Payment ▢ Self Pay ▢ EAP ▢ Insurance ▢ Other

If payment is by insurance please complete the section below:

Name of Insurance Company _____

Insurance ID Number_____ Group Name and Number _____

Phone Number of Company _____

Is Preauthorization required? ▢ No ▢ Yes Is Physician Referral required? ▢ No ▢ Yes

Who is the Insured Member if not the Patient

Name: _____ Relationship: _____

Address: _____ City _____ ST: _____Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Date of Birth __ __ / __ __ / __ __ __ Social Security Number __ __ __ - __ __ - __ __ __

Employer: _____

Employer Address: _____

▢ **I DO** give my permission for Decatur Psychological Associates, P.C., to bill my insurance company for services rendered.

▢ **I DO NOT** give my permission for Decatur Psychological Associates, P.C., to bill my insurance company for services rendered.

Name (please print) _____

Signature _____

Date _____