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INSURANCE INFORMATION

Insurance Company Name: _____

Claims Office Address: _____

Insured's Name: _____

Insured Date of Birth: _____

Insured Employer: _____

Insured Social Security Number: _____

Membership Number: _____

Group Name and Number
of Policy (If applicable): _____

CLIENT WILL PAY FOR SERVICES AT THE TIME THEY ARE RENDERED AND ASSIGNMENT OF ANY INSURANCE BENEFITS, AS UNDERSTOOD BY THE CLIENT, WILL GO TO THE CLIENT, UNLESS THE PROVIDER IS A NETWORK PROVIDER OF CLIENTS INSURANCE PLAN. THE PROVIDER OF SERVICES WILL FILL OUT ALL NECESSARY PAPERWORK IN ORDER FOR THE CLIENT TO RECEIVE SUCH BENEFITS. THE PROVIDER IS NOT RESPONSIBLE FOR THE REIMBURSEMENT DUE THE CLIENT BY THEIR INSURANCE COMPANY, NOR CAN GUARANTEE SUCH REIMBURSEMENT OR THE AMOUNT OF THE REIMBURSEMENT. THE CLIENT UNDERSTANDS THIS OFFICE POLICY:

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____