Arkansas Psychiatric Clinic

Insurance Information

As a courtesy to our patients we will file your Insurance Claims for you, both Primary and Secondary. We will need a copy of your insurance cards. It is your responsibility to give us updated insurance information prior to your appointments, if your policy changes.

I understand that I am responsible for payment should my insurance company not cover the services rendered to me by Arkansas Psychiatric Clinic, Inc.

By signing this agreement, I authorize Arkansas Psychiatric Clinic, P.A., to file my insurance claims, requesting that payment be sent directly to them. This authorizes the release of information to my insurance company, as necessary to process my claims. A photocopy of ***this authorization can be sent to my insurance company upon request.***

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Signature of Insured or Guardian (if patient is a minor) Date Authorization Given

Primary Insurance Company

Insurance company name:_____

Policy Holder_____ Employer Group Name_____

Policy Holder ID#_____ Group Number_____

Policy Holder SS#_____ Date of Birth_____

Insurance Company Phone #_____Authorization #_____

Patient's Relationship to Policy Holder ❑ self ❑ spouse ❑ child ❑ other

Secondary Insurance Company

Insurance company name:_____

Policy Holder_____ Employer Group Name_____

Policy Holder ID#_____ Group Number_____

Policy Holder SS#_____ Date of Birth_____

Insurance Company Phone #_____Authorization #_____

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Patient's Relationship to Policy Holder ❑ self ❑ spouse ❑ child ❑ other