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INSURED/RESPONSIBLE PARTY INFORMATION

Please complete this section regardless of insurance coverage.

Patient Name: _____

Full Name of Insured: _____

Relationship: _____ Occupation: _____

Home Address: _____ City, State, Zip: _____

Phone: _____

Insured SSN: _____ Driver's Lic. # _____

Primary Insurance Company: _____

ID #: _____ Policy #: _____

OFFICE BILLING AND INSURANCE POLICY

1. I authorize the use of this form on all of my insurance submissions.
2. I authorize the release of information to my insurance company.
3. I authorize direct payment to my service provider
4. I hereby permit a copy of this to be issued in place of the original.

Signature of Patient/
Parent or Guardian:

Date: