MIND HEALTH INSTITUTE
MISSION VIEJO

Insurance Information

**Please remember that we do not accept any form of insurance or participate in any insurance panels. If you choose to pursue reimbursement from your insurance company on your own, a service invoice can be provided. The following 'Insurance Information' form is merely to assist in facilitating medication approval or other covered services.*

Patient Name: _____
First *Middle* *Last*

Birth date: _____/_____/_____ Age: _____ SSN: _____ Gender _____

Address: _____

Phone #'s: Home ( )_____ Cell ( )_____ Work ( )_____

Email: _____ Fax: (_____)_____

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered

Employment Status: ☐ Employed Full-Time ☐ Employed Part-Time ☐ Student ☐ Unemployed

Information for the insurance policy holder (if different from above):

Client's relationship to the policy holder: ☐ Self ☐ Spouse ☐ Dependent ☐ Other: _____

Policy Holder's Name: _____
First *Middle* *Last*

Policy Holder's Birth date: _____/_____/_____ Policy Holder's SSN: _____

Policy Holder's Address: _____

Policy Holder's Phone #'s: Home ( )_____Work ( )_____

Policy Holder's Employer: _____

Insurance company information:

Name of insurance company: _____

Address of insurance company: _____

Policy Holder's ID #: _____ Policy Holder's Group #: _____

Name or Type of Plan: ☐ PPO ☐ Indemnity ☐ HMO ☐ EAP ☐ Other: _____

Phone number for verification of benefits (on back of card): _____

Does your plan cover mental health care with a psychiatrist? ☐ Yes ☐ No

Does your plan cover psychiatric medications? ☐ Yes ☐ No

Name of primary care physician: _____ Phone #: ( )_____