PORTLAND DBT INSTITUTE, INC
5200 SW MACADAM AVENUE, STE 580 PORTLAND, OREGON 97239

PHONE: (503) 231-7854 **FAX: (503) 231-8153**

INSURANCE INFORMATION FORM

PRIMARY INSURANCE

Subscriber's name_____ DOB_____SS#_____

Address_____City_____State_____ Zip_____

Client's relation to insured_____ Phone: _____

Insured's employer_____

Primary insurance company_____

Address_____City_____State_____ Zip_____

Phone_____

Identification #_____ Group #_____

Deductible amount $_____ Deductible met? __ Yes __ No

If no, how much left? $_____ Pre-existing policy? ____Yes ____No

Effective Date_____

Preauthorization required? ____ Yes ____ No

Name and number of contact for preauthorization_____

Limits of mental health benefit? ____Yes ____No _____ sessions per year $_____ per year

Mental health benefit currently available ____all ____ or part

If part, how much left? $_____

The Portland DBT Institute has my permission to bill my insurance company. I authorize the program to release any information necessary to process my claims. I further authorize that my insurance benefits be paid directly to the program.

Name:_____ Relation to Client:_____

Signature:_____ Date_____

Effective 4-1-2009:

Primary and Secondary Insurance: As a courtesy, we will bill your primary insurance for services rendered. You will be required to pay the balance remaining after your primary insurance has paid. We do not bill secondary insurance. However, we will be happy to provide you with a statement for your secondary insurance should you wish to recover your out-of-pocket expenses directly from them.