efac

PREAUTHORIZATION FOR HEALTH CARE

- I authorize **Gerda Murphy, LCSW** to keep my signature on file for billing purposes.
- I authorize **Gerda Murphy, LCSW** to release to insurance/EAP company all information necessary for claims payment purposes.
- I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to this clinic.

Client's Name: _____

Client's D.O.B. _____/_____/_____

Client's Home Address: _____

City: _____ State:_____ Zip: _____

Tel #1: _____ Circle: cell home work Circle*: OK to leave message*

Tel # 2:_____ Circle: cell home work Circle*: OK to leave message*

Name of parties with whom we may leave messages: (1) _____/Relationship:_____

(2) _____/Relationship:_____(3)_____/Relationship:_____

EMERGENCY CONTACT: Name _____ Telephone # _____

Patient Status: Single _____ Married _____ Other_____

Employed _____ Full-time Student_____ Other_____

Relationship to Insured: Self _____ Spouse _____ Child _____ Other _____

Insured's Name: _____ D.O.B. _____/_____/_____

Insured's Home Address: _____

City: _____ State:_____Zip: _____ Insured's SS# _____

Insured's Policy #: _____ Group #: _____

Insured's Employer's Name: _____

Patient or Insured's Signature: _____

Date: _____/_____/_____ REFERRED BY: _____

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