JOANNE NAEGELE, M.A., L.P.C.C

2472 Overlook Road #4 Cleveland, Ohio 44106 (216) 791-2711

INSURANCE PROFILE

PERSONAL

PATIENT:_____ DATE OF BIRTH:_____
ADDRESS:_____
_____
S.S.N:_____ PHONE:_____
MAY WE LEAVE A MESSAGE:___☐___Yes ___☐___No

INSURANCE

POLICY HOLDER:_____
DATE OF BIRTH:_____ RELATIONSHIP TO PATIENT:_____
INSURANCE COMPANY:_____
CLAIM ADDRESS:_____
_____
INSURANCE PHONE (mental health number, if listed):_____
GROUP NUMBER:_____

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SECONDARY POLICY HOLDER:_____
DATE OF BIRTH:_____ RELATIONSHIP TO PATIENT:_____
INSURANCE COMPANY:_____
CLAIM ADDRESS:_____
_____
INSURANCE PHONE (mental health number, if listed):_____
GROUP NUMBER:_____

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I hereby authorize **Joanne Naegele**, M.A., L.P.C.C. to release any information required by my insurance company to process claims. I also recognize that Ms. Naegele is an OUT OF NETWORK provider with my insurance carrier. I agree to be responsible for payment for services rendered.

Signature_____ Date_____

(For office use only)
Deductible_____Co-Pay_____Co-Insurance_____

Visit Limit_____Diagnosis_____