# Wendy G. Newton, Psy.D.

**3939 NE Hancock Street, Suite 314, Portland, OR, 97212**
**Phone: (503) 869-9092 ~ FAX: (503) 473-8273**


## Billing Information

***Please bring your insurance card (or a copy of it) to your first appointment.***

Client Name:_____ DOB: _____

Gender: M F Other Marital Status:_____

Address:_____ City:_____ Zip: _____

Home Phone:_____ Work Phone: _____

Cellular:_____ Email: _____

May messages be left for you at home?_____ At work?_____ Cell?_____ Email?_____

**Primary Insurance Carrier:**_____ Phone: _____

Claims Address:_____ City:_____ Zip: _____

Name of Insured:_____ Relation to Client: _____

Insured ID Number:_____ Group Number: _____

Insured DOB:_____ Phone:_____ Employer: _____

Insured's Address:_____ City:_____ Zip: _____

(To be completed by provider)

Deductible amount $_____ _per person __ per family _per fiscal yr __per calendar yr __per policy yr Has deductible been met? __Yes _No If no, how much left? $_____

Benefit_____% of _charges __usual and customary Copay/CoIns $_____

Limits of mental health benefit? __Yes __No _____# of sessions __ per year *or* __ per 24 month period *or*_____

Mental health benefit currently available __all *or* __part If part, how much left? _____

Preauth required? __Yes _No Name & number of contact for preauth_____

**Secondary Insurance Carrier:**_____ Phone: _____

Claims Address:_____ City:_____ Zip: _____

Name of Insured:_____ Relation to Client: _____

Insured ID Number:_____ Group Number: _____

Insured DOB:_____ Phone:_____ Employer: _____

Insured's Address:_____ City:_____ Zip: _____

**I hereby authorize the release of all medical information necessary to process an insurance claim. I hereby authorize my insurance carrier to make payments directly to Wendy Newton, Psy.D. I understand that I am financially responsible for all charges, regardless of insurance, unless otherwise written by Wendy Newton, Psy.D.**

Signature_____ Date: _____