Dr. Vivian Sierra, LLC

Client Insurance Information (PLEASE PRINT)
Full Name____DOB_____/____/_____
Address:____
City: ___________________________ State____________________ County
____
Phone: home_______________ work __________________mobile________________
Employer:____
Insured's name____
Relationship to Insured ______________________
Insured's DOB:____
Address of Insured (If different than client)
Street____
City: ___________________________ State____________________
County________________
Phone: ______________________
Insured's Employer____
Primary Insurance Co:
____ _______
ID # ____ GROUP # __________________
Plan Name ____
Contact phone number for insurance company (on back of card)
Members ________________________ Providers________________________
Mental Health/SA _______________ Precertification_____________________

Please contact your insurance company to verify your benefits as well. You will want to be aware of your deductible, copay/coinsurance, number of sessions per year, authorization (if necessary), and if they reimburse for the specific service that you are request (office visit for individual, family therapy or group counseling).

PLEASE NOTE: INSURANCE COMPANIES WILL NOT PAY FOR MISSED SESSIONS. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR THE FULL INSURANCE RATE IF I DO NOT GIVE 48 HOUR NOTICE.

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Signature