E. Mark Sullivan:
Diagnosis _____

Please complete with Name as it appears on Insurance Card

Client Last Name _____First Name _____MI____ DOB ____/____/____
Gender: M F SSN: _____ Marital Status: Married Single
Home Street_____City_____State____ Zip_____
Home Phone (_____)-_____-_____ Cell (_____)-_____-_____ Work (_____)-_____-_____EX_____

Email: _____

PRIMARY INSURANCE INFORMATION: Must be completed to bill your Insurance

Insurance Name: _____ Plan Name: _____
Address: _____ Deductible _____Visit co-pay_____
Subscriber ID: _____Group No: _____
Clients Relationship to Primary Insured: (**required circle one**) Self Spouse Child Other

If client is not the policy holder please complete the section below:

Policy Holder Name:_____ _____MI____ DOB _____/_____/_____
Gender M F SSN: _____ Marital Status: Married Single

Policy Holder Address:_____City_____State____
Zip_____Phone (_____)-_____-_____Email: _____

Insurance Authorization No:_____ Number of Authorized Sessions:_____

Authorization Start Date: ____/____/_____ Authorization Stop Date: ____/____/_____

Secondary Insurance

Policy Holder Name: _____MI____DOB____/____/_____ Gender M F
SSN: _____Relationship to client_____
Insurance Name_____ Plan Name: _____
Address:_____
Subscriber ID: _____Group No:_____

Links Medical Billing Solutions will bill your insurer directly for all services. Your signature expresses your agreement that the dates of service, services rendered, and diagnosis will be provided to Links Medical Billing Solutions for billing purposes only. Signature also indicates liability for any balance due. The client's or responsible person's signature below authorizes release of any medical information requested by the insurer in order to process insurance claims and authorizes payment of medical benefits to be made directly to the supplier of services.

Signature_____**Date**_____