Comprehensive Counseling Center, LLC

CLAIM FORM

Patient Information	Provider Information
Patient Name:______________________________	***Comprehensive Counseling Center, LLC*** ***2358 Rt. 9 South, Suite B5*** ***Howell, NJ 07731*** ***732-987-9770*** ***732-987-9769***
Address:__________________________________	
City/state/Zip:______________________________	
Insurance:_________________________________	**Provider's Name:** ______________________________
Date of Birth_______________________________	**Provider's Signature:** ___________________________
Policy #___________________________________	**Tax ID Number: 90- NJ License #**___________

Notice to Patient: Complete patient information section, sign, and date.

Authorization to release information: I hereby authorize the release of any information acquired in the course of my evaluation and treatment.
Signature____**Date**____________________________

Authorization to Assign Benefits: I hereby authorize payment to be made directly to the provider.
Signature____**Date**____________________

DIAGNOSIS		

FROM: LOCATION __OFFICE __HOME __HOSPITAL __OTHER
IS CONDITION RELATED TO AUTO ACCIDENT? __YES __NO IS CONDITION RELATED TO EMPLOYMENT __YES__NO

Procedure	Dates	CPT Code	Rate	Amount
Diagnostic Interview/Exam		90791		
Psychotherapy 45 -50 minutes		90834		
Individual 60 minutes		90837		
Report Preparation				
			Total paid	
			Check #	