Dr. Thomas A. Parker & Associates

TAPA Patient Insurance Authorization Form

Patient's NAME: _____

Patient's Birth date: _____Tele. #_____

Patient's Social Security #:_____

Patient's Address:_____

Patient's EMAIL address _____

Patient's Employer or School_____

Pre-Certification/Authorization # and effective date, if applicable_____ __/__/__

Patient Insurance Authorization Telephone Number_____

Patient's Insurance Plan Name or Program Name_____

Patient's Insurance ID Number_____

Insurance Group Number_____

Client Co-Pay Amount for Specialist*_____

I request that payment of my insurance benefits coverage be made payable to Dr. Thomas A. Parker for mental health Care provided for me by Dr. Thomas A. Parker and Associates. I understand my signature requests that payment(s) be made by my insurance company, _____ to Dr. Thomas A. Parker and I authorize a release of all necessary information to pay the claim.

Each patient is responsible for the payment of all portions of the bill that the insurance company does not cover.

Patient's Signature/Patient's Representative **Date**

Counselor's Signature **Date**

* Clients may need to contact their insurance company for some information.

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