Tonya Boyd, PsyD

Psychologist
535 SE Washington ST
Hillsboro, OR 97123
(503) 840-2053

Client name_____Date of birth _____
Mailing Address _____ Phone # _____

PRIMARY INSURANCE INFORMATION

Name of Insured _____ ❑Self ❑Spouse ❑Parent ❑Other

Mailing Address _____ Phone # _____

Employer _____
Insurance Company _____ Phone # _____

Insurance Address _____
Group #_____Identification # _____
Effective date_____D.O.B. of insured (if not client) _____
Mental Health Insurance Carrier _____
Insurance Address _____
Insurance Phone # _____
Deductible Amount _____ Met? ❑ Yes ❑ No Copay per Visit _____

Preauthorization required? ❑No ❑Yes If yes, # of sessions authorized? _____
Maximum # sessions/year?_____Maximum $ amount/year? _____
Mental health benefit available: ❑ All ❑Part $ _____
Do you have secondary insurance coverage? ❑Yes ❑No If "yes" please provide the above information for secondary carrier using the back of this form.

Please read and sign

We bill insurance as a service to you. We are not responsible for assuring that you have initial or ongoing coverage. If your coverage or authorization expires, for any reason, we will hold you responsible for payment. Please keep abreast of your coverage maximum.

I understand the insurance policy and I authorize Dr. Boyd to release information to insurance carrier(s) necessary to process insurance claims for services provided. I also authorize my insurance carrier to assign benefits directly to Dr. Boyd. I have called my mental health insurance carrier to verify coverage and obtain needed authorization.

_____ _____
Signature of Responsible Party Date