

TIME OF SERVICE FORM
Emily Nemeth, LPC

A. PATIENT INFORMATION

First Name	Middle	Last	Birth Date	Sex
Street Address		City	State	ZIP
Home Phone	Work Phone	Cell Phone	Ok to leave voicemail?	

B. CONTACT PERSON (name)

Relationship

Message Phone	Email
SEND BILLS TO (name)	Relationship
Mailing Address	Phone
Email Address	Email bills? Y N

C. PRIMARY INSURANCE

Insurance Company & Phone #	Effective date:		
Insurance Claims Mailing Address			
Name of Policy Holder	ID #	Group #	
Date of Birth	Relationship to Patient	Sex	Policy Holder's Employer
Insured's address if not listed above		Insured's phone #	

D. SECONDARY INSURANCE? No Yes

Insurance Company & Phone #	Effective date:		
Insurance Claims Mailing Address			
Name of Policy Holder	ID #	Group #	
Date of Birth	Relationship to Patient	Sex	Policy Holder's Employer
Insured's address if not listed above		Insured's phone #	

OUTPATIENT MENTAL HEALTH BENEFITS

Date & Time:		Person talked to:			
Co-pay \$	Deduct \$	OOP Max \$			
Co-Insur	%	Ded met \$	OOP met	still co-pay?	Y N

Session limits:	Notes:
Referral N Y Pre-Auth N Y	
Auth #	
Exclusions:	referral/auth/pre-auth steps:
Covered CPTs: 90791 (dx interview) 90834 (45 min) 90837 (60 min)	
90846 (fam no pt) 90847 (fam w/pt) 90853 (grp) 96101 (psych test) 90785 (+complexity)	
Additional covered CPTs:	

Please return this form along with a copy of the front and back side of your insurance card to my biller before your first visit.

Medical Billing Northwest
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