



ICARD
PLLC

701 W. 7th Ave, Suite 130 Spokane, WA 99204

Tax ID: 91-2150878

Ph: (509) 838-3932 Fax: (509) 838-1163

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ACCOUNT INFORMATION-PRIVATE INSURANCE

Client's Name: _____
Last First Middle Initial

Address: _____
Street City State Zip Code

Client's DOB: ____/____/____ Gender _____

Phone: Home: (____) _____ Cell: (____) _____ Work: (____) _____

E-mail: _____

Mother/Father/Other _____ Name: _____

Phone: Home: (____) _____ Cell: (____) _____ Work: (____) _____

Mother/Father/Other _____ Name: _____

Phone: Home: (____) _____ Cell: (____) _____ Work: (____) _____

Payment Source: (check all that apply)
____ Insurance ____ DDD ____ Private Pay (Cash/Check) ____ Other _____

Primary Insurance Information (If applicable)

Primary Cardholder/Subscriber Information:

Name: _____ DOB: ____/____/____

Insurance ID/SSN Number/: _____ Group/Program Number: _____

Subscriber's Employer: _____ Phone: (____) _____

You must call your insurance company and document coverage before your appointment time.

Date Called: ____/____/____ Time: _____ am/pm

Name of Insurance Company you are calling: _____

Phone Number of Insurance Company: (____) _____

Name of Person/Contact you spoke to: _____

Questions to Ask:

1. Does my plan have benefits for mental health/psychological testing services? Yes ___ No ___
2. What is the effective date of my insurance? _____
3. Do I have a deductible? Yes ___ No ___ If yes, what is the remainder? _____
4. What does my plan cover for mental health/psychological testing services?
50% ____ 60% ____ 70% ____ 80% ____ 90% ____ 100% ____ Other % ____
5. Do I have a co-payment? Yes ___ No ___ If yes, what is the amount? _____
6. Do I need a referral from my primary care provider (PCP)? Yes ___ No ___ If yes, please have your PCP fax a referral to us at (509) 838-1163
7. Do I need preauthorization for testing? Yes ___ No ___ For mental health? Yes ___ No ___
8. Treatment plan required? No ___ Yes ___ After ____ visits.