Shane Blasko Psychotherapy, LLC

Dr. Shane Blasko, Ph.D.

**AETNA INSURANCE REGISTRATION FORM**

(Please Print)

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| --- | --- | --- | --- | --- | --- | --- |
| Today’s date: / / | | | | | | |
| **CLIENT INFORMATION** | | | | | | |
| Last name: First: Middle | | | Sex: | Marital Status:  Single/Mar/Div/Sep/Wid | |
| Birth Date:  / / | | | Age: | Email (if wish to be contacted this way) | |
| Home Address: | | Phone: | | | | |
| P.O. Box | City: | State: | | | Zip Code: | |
| Occupation/Student: | | Employer/University Name: | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **INSURANCE INFORMATION** | | | | | | | |
| (Please provide your insurance card) | | | | | | | |
| Name of Primary Insurance Holder: | | Address (if Different): | | | | Birth Date:  / / | |
| Occupation: | | Employer: | | | | Phone Number: | |
| Client’s relationship to primary insurance holder: | Self | Spouse | | Child | Other | | Co-payment:  $ |
| Type of Aetna insurance (Full Name, Description on Card ex. Choice POS II) | | | | | | | |
| Group Number: | | | Policy Number: | | | | |

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| **OFFICE BILLING AND INSURANCE POLICY** |
| The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Dr. Shane Blasko and Shane Blasko Psychotherapy, LLC. I understand that I am financially responsible for any co-payment and unpaid balance. I also authorize Shane Blasko Psychotherapy, LLC or Aetna Insurance Company to release any information required to process my claims. I further understand that it is my responsibility to pay any deductible amount, co-pay, co-insurance amount, or any balance not paid by my insurance the day and time of my appointment. There is a $25.00 service charge on all returned checks.  Client Signature Date |