JOCIE SWEENEY, PHD
Your Charlotte Psychologist

Licensed Psychologist
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Charlotte, NC 28202
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Insurance Verification Form
Complete prior to your intake session
You must contact your insurance company for some of this information

CLIENT INFORMATION:
Last Name: _____First Name: _____ M.I. : _____

DOB: _____ Sex : _____

Address: _____

City: _____ State: _____ Zip:_____

Employer: _____ Cell Phone: _____ Work Phone:_____

POLICY HOLDER INFORMATION (if different from client):
Last Name: _____ First Name: _____ M.I.: _____

DOB: _____ Sex: _____

Address:_____

City: _____ State: _____ Zip:_____

Employer: _____ Cell Phone: _____ Work Phone:_____

Relationship to Client:_____

CONTACT YOUR INSURANCE PROVIDER PRIOR TO YOUR INTAKE SESSION!

PRIMARY INSURANCE COMPANY INFORMATION:
Name of Insurance Company:_____

Address to Mail Claims:_____

_____

Phone Number for Authorization:_____

Policy Number/ ID Number: _____ Group Number:_____

1) Is pre-authorization required for mental health services (CPT codes 90791, 90837, or 90853)?
   a. Authorization Number: _____
   b. # Sessions Authorized: _____
2) In-Network Psychotherapy Co-Pay/Co-Insurance:$_____
3) In-Network Deductible: $_____
4) Have you verified that Dr. Sweeney (NPI 1538578299) is an in-network provider for this plan? **Yes No**
   a. if you have not verified OR Dr. Sweeney is not in-network, please be sure to understand your out-of-network benefits
5) Out-of-Network Psychotherapy Co-Pay/Co-Insurance:$_____
6) Out-of-Network Deductible: $_____

I authorize the release of any psychological information necessary to process my insurance claims. I authorized direct payment of healthcare benefits to Jocie Sweeney, PhD (SweeneyPsych, PLLC) for any professional services provided by her. The signatures below are effective for the length of time that I am in treatment with Jocie Sweeney, PhD (SweeneyPsych, PLLC) and for as long as it takes for the claims to be processed.

_____ _____
Signature Date

_____ _____
Jocie Sweeney, PhD Date