Maidena A. McLerran, Ph.D.
Clinical Psychologist
California Psychologist License PSY 9847

851 Fremont Ave, Suite 107
Los Altos, CA 94024
650-565-8534
www.drmaidena.com

INSURANCE INFORMATION

Please provide a photocopy—both front and back--of your insurance card. If the information requested below is on the insurance card, then you do not need to fill in the information below. Please do provide any additional information not on your card requested below.

Name of Insurance Company: _____

Name of Policy Holder: _____

Relationship to Patient (circle one): Self Spouse Parent Other

ID#: _____

Group Name (usually the name of your employer): _____

Group Number: _____

Mailing Address for Claims:

Name: _____

Street/P.O. Box: _____

City: _____ State: _____ Zip: _____

Phone: _____

(Continued on reverse)

Authorization #: _____

Co-pay for First Session: _____

Co-pay for Additional Sessions: _____

Deductible Amount Remaining: _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Maidena A. McLerran, Ph.D. to release to my Insurance Company(s) including but not limited to Aetna, Magellan Health and affiliates, Project Concern EPA, United Behavioral Health, U. S. Behavioral Health Service, Victim Witness, any information about myself or my dependents necessary to process my insurance claim(s). I agree this authorization shall be valid while my claim(s) are pending.

Printed Name: _____ Date: _____

Signature: _____