

PORTLAND DIALECTICAL BEHAVIOR THERAPY PROGRAM, PC  
5200 SW MACADAM AVENUE, STE 580 PORTLAND, OREGON 97239

PHONE: (503) 231-7854

FAX: (503) 231-8153

INSURANCE INFORMATION FORM

PRIMARY INSURANCE

Insured's name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Client's relation to insured \_\_\_\_\_ Phone: \_\_\_\_\_  
Insured's employer \_\_\_\_\_

Primary insurance company \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_  
Identification # \_\_\_\_\_ Group # \_\_\_\_\_  
Deductible amount \$ \_\_\_\_\_ Deductible met?  Yes  No  
If no, how much left? \$ \_\_\_\_\_ Pre-existing policy?  Yes  No

Effective Date \_\_\_\_\_  
Preauthorization required?  Yes  No  
Name and number of contact for preauthorization \_\_\_\_\_  
Limits of mental health benefit?  Yes  No \_\_\_\_\_ sessions per year \$ \_\_\_\_\_ per year  
Mental health benefit currently available  all  or part  
If part, how much left? \$ \_\_\_\_\_

The Portland DBT Program has my permission to bill my insurance company. I authorize the program to release any information necessary to process my claims. I further authorize that my insurance benefits be paid directly to the program.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Effective 4-1-2009:**

**Primary and Secondary Insurance:** As a courtesy, we will bill your primary insurance for services rendered. You will be required to pay the balance remaining after your primary insurance has paid. We do not bill secondary insurance. However, we will be happy to provide you with a statement for your secondary insurance should you wish to recover your out-of-pocket expenses directly from them.