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 |