

Susan Thau, Ph. D.

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Patient Insurance Form

I authorize Susan Thau, Ph.D., to use the following information to submit billing to the insurance company listed below. I understand that the electronic billing is compliant with the Health Insurance Portability and Accountability Act (HIPAA) and Dr. Thau will maintain my privacy.

Name _____

Address _____

Date of Birth _____

Telephone _____

Social Security Number _____

Insurance

Name _____

Group Number _____

Subscriber Number _____

Address of Insurance Co. _____

Patient/Responsible Party _____

Date _____