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### INSURANCE INFORMATION

Client Name: \_\_\_\_\_

(First)

(Last)

Client's Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender of client:  Male  Female

Client's Address (stress/city/zip): \_\_\_\_\_

Client's Phone: (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Client Status:  Single  Married  Other  Employed  Full-time student  Other  
(check all that apply)

**("Policy Holder" refers to the name of the person who holds the insurance plan)**

Client's relationship to the policy holder:  Self  Spouse  Child  Other: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

(First)

(Last)

Policy Holder's Address: \_\_\_\_\_

Policy Holder's Phone: (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Policy Holder's Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender of Policy Holder:  Male  Female

Name of Insurance Company: \_\_\_\_\_

Policy Holder's ID #: \_\_\_\_\_ Policy Holder's SS#: \_\_\_\_\_

Group #: \_\_\_\_\_

Name or Type of Plan:  PPO  Indemnity  HMO  EAP  Other: \_\_\_\_\_

Phone number for verification of benefits/eligibility (on back of card): (\_\_\_\_) \_\_\_\_\_

Address to send billing (on back of card): \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

What do you know about your deductible amounts? \_\_\_\_\_

Do you know how much of your deductible you have met?  No  Yes, amount: \_\_\_\_\_

Does your insurance plan cover mental health treatment with a psychiatrist?  No  Yes

What is your co-pay, or what percentage of the fee are you responsible for? \_\_\_\_\_

How many sessions are allowed in your plan? \_\_\_\_\_ How many sessions were approved? \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_