TIME OF SERVICE FORM
Anita Abelsen-Gay, MA, LPC

A. PATIENT INFORMATION

First Name	Middle	Last	Birth Date	Sex
Street Address	City	State	ZIP	
Home Phone	Work Phone	Cell Phone	Ok to leave voicemail?	

B. CONTACT PERSON (name) Relationship

Message Phone	Email
SEND BILLS TO (name)	Relationship
Mailing Address	Phone
Email Address	Email bills? Y N

C. PRIMARY INSURANCE

Insurance Company & Phone #		Effective date:	
Insurance Claims Mailing Address			
Name of Policy Holder		ID #	Group #
Date of Birth	Relationship to Patient	Sex	Policy Holder's Employer
Insured's address if not listed above			Insured's phone #

D. SECONDARY INSURANCE? No Yes

Insurance Company & Phone #		Effective date:	
Insurance Claims Mailing Address			
Name of Policy Holder		ID #	Group #
Date of Birth	Relationship to Patient	Sex	Policy Holder's Employer
Insured's address if not listed above			Insured's phone #

Please return this form with a copy of the front and back side of your insurance card to Medical Billing Northwest before your first visit.

Medical Billing Northwest
PO Box 448
Canby, OR 97013
P: 503-592-9333 F: 503-592-9334
Email: brooke@medicalbillingnorthwest.com