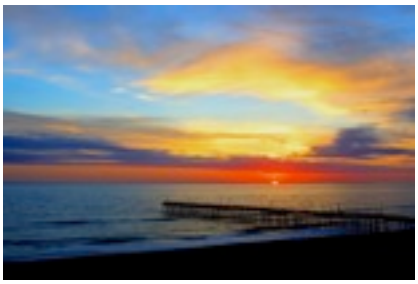

Ed Wojniak, PhD
Daybreak Counseling
Clinical and Consulting Psychology
3620 N. High Street, Suite 209
Columbus, Ohio 43214
614.268.3939
Fax: 614.268.3949

HEALTH INSURANCE CLAIM FORM

Your insurance plan is a contract between you and your carrier, and we are not a party to that contract. While filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date services are rendered. Our office will file with your insurance company as services are rendered, and if your insurance carrier fails to respond to the initial claim, we will resubmit your claim one additional time to attempt to recover their payment. If your insurance carrier fails to pay the second submission, you will be responsible for the entire balance on your account.

Please initial here to indicate that you have read and understand the above policy statement: _____

PATIENT INFO

	LAST NAME	**FIRST NAME**	**MIDDLE INITIAL**
Circle relationship to policy holder:	self	spouse child	other
ID # on insurance card:			
Group # on insurance card:			
Insurance Plan or Program Name:			
Is there another health benefit plan?	yes (specify on back)	no	

POLICY HOLDER INFO (if different from patient)

	LAST NAME	FIRST NAME	MIDDLE INITIAL
Street Address:			
City, State, Zip:			
Primary Telephone Number:			
Date of Birth:			
Social Security #:			
Gender:	male	female	

I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to Ed Wojniak, PhD., Inc. for services provided.

Signature _____

Date _____