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Psychotherapy and Behavioral Health Services

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**Insurance/Billing Information**

Insurance Provider: \_\_\_\_\_ ID #: \_\_\_\_\_

Plan Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Plan Subscriber Employer: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Information of the Insured:**

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

Relationship to Insured (if not self): \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Birth Date: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

\_\_\_\_\_

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