Drayton's View
Therapy and Wellness Services, PLLC
Where Healing Meets Perspective
910-929-2103 | connect@draytonsviewtherapy.com | draytonsviewtherapy.com
130 Pine State Street Suite C, Lillington, NC 27546

Insurance Verification Form

- Client Full Name: _____
- Date of Birth: ____ / ____ / _____
- Phone Number: _____
- Email Address: _____

Insurance Information

- Primary Insurance Company: _____
- Insurance Phone Number (on back of card): _____
- Policy/ID Number: _____
- Group Number: _____
- Policy Holder's Full Name: _____
- Policy Holder's Date of Birth: ____ / ____ / _____
- Policy Holder's Address (if different): _____

Secondary Insurance (if applicable)

- Secondary Insurance Company: _____
- Policy/ID Number: _____
- Group Number: _____
- Policy Holder's Full Name: _____
- Policy Holder's Date of Birth: ____ / ____ / _____

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Coverage Information (completed by client or office)

- Type of Plan: ☐ HMO ☐ PPO ☐ POS ☐ Other: _____
- Does plan require authorization/referral? ☐ Yes ☐ No
- Mental Health Benefits Phone # (from card): _____
- Deductible (amount and status): _____
- Co-Pay per Session: _____
- Co-Insurance %: _____
- Number of Sessions Allowed per Year: _____
- Effective Date of Policy: ____ / ____ / _____
- Out-of-Network Coverage? ☐ Yes ☐ No

Client Responsibilities

- I understand that I must provide a valid insurance card and photo ID prior to services.
- I understand that I am responsible for any fees not covered by my insurance, including co-pays, deductibles, co-insurance, late cancellations, or no-show fees.
- If I fail to disclose secondary insurance, I am responsible for denied claims and balances owed.

Client/Guardian Signature: _____ Date: ____ / ____ / _____
Witness/Staff Signature: _____ Date: ____ / ____ / _____