Shelly Khaldi, LMHC

Billing Registration Form

First Name: _____ Middle Initial: _____ Last Name: _____ Date of Birth: _____

Gender: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Email Address: _____

Please provide front and back copies of your insurance card for insurance verification purposes

Failure to return this form along with front and back of insurance card 24 hours prior to your appointment will result in having to self-pay for office visit.

Primary Insurance Company: _____ Member ID Number: _____ Group Number: _____

Insured Name: _____ Insured Phone: _____ Insured Date of Birth: _____

I provide my consent for Shelly Khaldi, LMHC to provide the above information to Innovative Billing Solutions for registration and/or verification purposes.

_____ _____

Signature Date