A. Raja Hornstein, PsyD

1330 LINCOLN AVENUE
SUITE 310
SAN RAFAEL, CA 94901-2143

PRIMARY INSURANCE AUTHORIZATION

Beneficiary Name___________________________________

Primary Insurance ID _______________________________

I request that payment of authorized benefits from my primary insurer,

____

be made to me or on my behalf to A. Raja Hornstein, PsyD for any services furnished me. I authorize the holders of medical information about me to release to the above named primary insurer and its agents any information needed to determine these benefits or the benefits payable for related services.

____ Date _____________________________

SECONDARY INSURANCE AUTHORIZATION

Beneficiary Name___________________________________

Secondary Insurance ID_____________________________

I request that payment of authorized benefits from my secondary insurer,

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be made to me or on my behalf to A. Raja Hornstein, PsyD for any services furnished me. I authorize the holders of medical information about me to release to the above named secondary insurer and its agents any information needed to determine these benefits or the benefits payable for related services.

____ Date _____________________________

calligraphy
xin: heart/mind

415 779 2499
WWW.DRHORNSTEIN.COM
RH@.DRHORNSTEIN.COM
CLINICAL PSYCHOLOGIST PSY21271