

Financial Information Form

I truly appreciate your choosing to come to me for psychological help. As part of providing high-quality services, we need to be clear about our financial arrangements.

• If you have health insurance, it may pay for a part of the cost of your treatment here. To find out if this is so, my staff and I need the information requested below. We will explain any part of this form that you do not understand.

• If you have no health insurance coverage, or do not intend to use it, please check here , complete sections A and E below, and return this form to me or my secretary.

A. Patient's name: _____ Birthdate: _____ Soc. Sec. #: _____
Address: _____ Home phone: _____
(If the patient is a dependent) Insured's/policy holder's name: _____
Occupation: _____ Employer: _____ Work phone: _____
Address of employer: _____

B. (If applicable) Spouse's name: _____ Birthdate: _____ Soc. Sec. #: _____
Occupation: _____ Employer: _____ Work phone: _____
Address of employer: _____

C. If you (or your spouse) have any of these kinds of insurance, please fill in the numbers and names for each one.

1. Blue Cross/Blue Shield

Name of subscriber (if not the patient): _____
Identification/agreement/policy #: _____ Group or enrollment #: _____
Plan #/code or BS #: _____ Effective date: _____
Location of plan: _____ Reciprocity #: _____
Phone: _____ Other information: _____

2. Commercial health insurance carrier/company

Name of company: _____
Name of policyholder (if not the patient): _____
Policy #: _____ Certificate #: _____
Phone: _____ Address to send claims: _____

D. For each kind of insurance you intend to use, you and I will have to make two decisions. First, we have to decide who will find the information to answer the questions below. Will you do this, or do you want this office to do it? The information will come either from your company's benefits office or from the insurance company. Then, when we have this information, we have to examine the treatment choices allowed by the coverage you have.

1. Company: _____ Effective date of coverage: _____
Deductible: \$ _____ per person or per family? or per diagnosis?

per fiscal year or per calendar year or per policy year?

How much of this deductible has been used so far? \$ _____

Benefit: _____ % of charges Usual, customary, and reasonable (UCR) Maximum charge of \$ _____

Other benefits:

Limitations: Number of visits: ____ Monetary limits: \$ _____ per _____ Lifetime limits: \$ _____

Is outpatient group psychotherapy covered? Yes No

Must a physician refer the client? Yes No

Does any rule about preexisting conditions apply here? No Yes, and the rule is: _____

Are there any other limitations (such as conditions not covered, service settings, maximum per-session charges, need for DSM or ICD diagnostic codes or CPT service codes)? _____

2. Company: _____ Effective date of coverage: _____

Deductible: \$ _____ per person or per family? or per diagnosis?

per fiscal year or per calendar year or per policy year?

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E. If you do not have insurance, how will you pay for services from this office? _____

F. I give this office permission to release any information obtained during examinations or treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.

G. I understand that I am responsible for all charges, regardless of insurance coverage.

H. Assignment of benefits

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the therapist above. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.

Client's (or parent/guardian's) signature,
indicating agreement to all of the statements above

Date

Printed name