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 ❑ , and complete sections A, B (if applicable) and E below, and return this form to me.

A. Patient's name: ____

Sex: M ❑ F ❑ DOB:________________ Soc. Sec. #: ____________________

Address:____

City: ____________________ State: ________ Zip code: ________________

Home #: ______________ Cell #: ______________ Work #:_______________

B. If applicable, Responsible Party:____

Custodial Arrangement:____

Names of parents/guardians/caretakers: ___________________________________

Address:____

City: ____________________ State: ________ Zip code: ________________

Home #: ______________ Cell #: ______________ Work #:_______________

C. If you have insurance, please fill in the information for each one.

1. **Name of Primary Insurance Company:**___________________________

Name, date of birth & social sec. # of policy holder (if different from patient):

Name:______________________ DOB:________ Soc.Sec.#:______________

Subscriber / policy #: _______________

Group or enrollment #:_______________

Authorization #: ______________________ Effective date:_______________

Address to send claims:_____________________ Phone #: _______________

Deductible: $_______ ❑ per person and/or $_______ ❑ per family?

❑ per fiscal year or ❑ per calendar year or ❑ per policy year? ❑ per diagnosis?

How much of this deductible has been met so far? $___________

Benefit: _____% of ❑ charges ❑ Usual, customary, and reasonable (UCR)

❑ Maximum charge of $_________

❑ Other benefits:____

Limitations: #of visits:_______ ❑per fiscal yr. or ❑calendar yr. or ❑policyyr.?

Co-pay: $_____ per session

2. **Name of Secondary Insurance Company:**_________________________

Name, date of birth & social sec. # of policy holder (if different from patient):

Name:______________________ DOB:_________ Soc.Sec.#:______________

Subscriber / policy #: ________________

Group or enrollment #:________________

Authorization #: ______________________ Effective date:_______________

Address to send claims:_____________________ Phone #: _______________

Deductible: $________ ❑ per person and/or $________ ❑ per family?

❑ per fiscal year or ❑ per calendar year or ❑ per policy year? ❑ per diagnosis?

How much of this deductible has been met so far? $___________

Benefit: _____% of ❑ charges ❑ Usual, customary, and reasonable (UCR)

❑ Maximum charge of $__________

❑ Other benefits:____

Limitations: #of visits:_______ ❑per fiscal yr. or ❑calendar yr. or ❑policyyr.?

Co-pay: $_____ per session

D. Do you have any other insurance coverage that applies here?
If yes, check here ❑ and fill in an empty section above.

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 provider above. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.

____ ______________

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

____ ______________

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