**Financial Information Form**

I truly appreciate your choosing to come to me for therapy. As part of providing high-quality services, I 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. I currently accept many Anthem, Humana, Cigna, Caresource and Aetna plans. In order to understand your ability to use any insurance, I need the information requested on the reverse side of this form. Please complete the requested information and I will explain any part of it you do not understand.

• If you have no health insurance coverage, or do not intend to use it, please check here ❑

My current, out-of-pocket rates are:

•$125 for an initial appointment (90 minutes)

•$80 for all following sessions (55 minutes)

•I accept payment via cash, check or major credit and debit cards.

•Payment is due at the start of each session.

•Should you find yourself unable to pay at the time of service, you may choose to pay that fee in addition to the fee for the next session at the start of the following appointment. If you are unable to pay for a second session, no further sessions will occur until full payment for all services rendered has been received.

•If your financial situation changes and you are concerned about your payment arrangement, please speak with me directly to find a solution.

•I have a 48-hour cancellation policy. If you do not come in for a scheduled appointment or have to cancel your appointment within 48 hours, a flat $50 fee will be charged and due prior to your next session.

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

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Client’s (or parent/guardian’s) signature, Date

indicating agreement to all of the statements above

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Printed name

**INSURANCE INFORMATION**

Please complete the following if you would like to explore use of your insurance to help pay for therapy.

**IF YOU HAVE ALREADY SUBMITTED A COPY/PHOTO OF YOUR INSURANCE CARD YOU DO NOT NEED TO FILL OUT THIS INFORMATION. SIMPLY SIGN BELOW.**

**A.** Patient’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_Soc. Sec. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
(If the patient is a dependent) Insured’s/policy holder’s name: \_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**B**. (If applicable) Spouse’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate: \_\_\_\_\_\_\_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_\_\_\_\_  
  
**C.** If you (or your spouse) choose to use insurance, please fill in the numbers and names for each one.

1. Name of Insurance Provider: ­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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. Name of Insurance Provider: ­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name of subscriber (if not the patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Identification/agreement/policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group or enrollment #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Plan #/code or BS #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Location of plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

•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.

•I understand that insurance may not cover any or all of the costs for therapy. I understand that by signing below, I am agreeing to pay the fees listed on the front of this form or any co-pays necessitated by my plan.

•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.

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Client’s (or parent/guardian’s) signature, Date

indicating agreement to all of the statements above

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Printed name