Financial Information Form

I truly appreciate your choosing to come to me for psychological help. 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. **It is your responsibility to obtain the following information:**

-What is your copay?

-Do you have a deductible that needs to be met before services are covered? (If so, it is your responsibility to pay upfront the full insurance rate at the time services are rendered)

-Do you need prior approval for mental health services? (If so, what is the contact information regarding getting prior approval?)

-Is there a limit to the number of sessions covered?

If your claim is denied by your insurance company for any reason, you will be responsible to pay for all sessions attended.

A. Client's name:_____ DOB: _____

1. Insurance Company _____

Name of subscriber (if different from Client): _____

Subscriber ID# _____

Co-Pay Amount? _____

2. Out of Network **Client acknowledges that it is their responsibility to find out if their insurance company will pay a portion of psychotherapy sessions and submits all superbills to their insurance company. Client pays for all sessions at time of service and accepts that their insurance company may not reimburse them for any/all monies paid to clinician.**

Client is utilizing OON benefits _____ Yes _____ No

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

4. Self-Pay

____ Clinician is not in network with client's insurance plan

____ Client does not have Out of Network benefits/deductible is too high

____ Client is choosing not to utilize insurance plan

Client's Signature: _____ Date: _____

Printed name: _____

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