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 different from patient): ________________
   Identification/agreement/policy #: ________ Group or enrollment #: ________
   Plan #/code or BS #: ________ Effective date: ________
   Location of plan: ________ Reciprocity #: ________
   Phone: ________ Provider's phone: ________
2. Commercial health insurance carrier/company
   Name of company: ________ Policy holder (if different from patient): ________
   Policy #: ________ Certificate #: ________
   Phone: ________ Provider's phone: ________
   Address to send claims: ________________
3. Health maintenance organization (HMO)
   Name of HMO: ________ Policy holder (if different from patient): ________
   Authorization #: ________ Agreement #: ________

(cont.)

Phone: ______________________ Provider's phone: ______________________

Address to send claims: ______________________

4. Medical Assistance

   List all numbers: ______________________

   (*Note:* Copayments by you are required.)

5. Medicare

   Agreement # with any letters: ______________________

   Railroad Medicare/Mine Workers Medicare: ______________________

6. Workers' compensation insurance

   Name of company: ______________________

   Policy #: ______________________ Certificate #: ______________________

   Address to send claims: ______________________

   Phone: __________ Treatment authorized by: ______________ Date of accident: ________

7. Do you or your spouse have any other insurance coverage that applies here (Tricare/CHAMPUS, motor vehicle insurance for an injury, etc.)? If yes, check here ❑ and fill in an empty section above.

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

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

   Benefit: ______% of ❑ charges ❑ Usual, customary, and reasonable (UCR) ❑ Maximum charge of $____

   ❑ Other benefits: ______________________

   Percent reduction, if any, for mental health? ______%

   Limitations: Number of visits: ________ Monetary limits: $__________ per ______________

   Lifetime limits: $__________

   Is outpatient group psychotherapy covered? ❑ Yes ❑ No

   Must a physician refer the client? ❑ Yes ❑ No

   Is psychological testing covered? ❑ Yes ❑ No

   Does any rule about preexisting conditions apply here? ❑ No ❑ Yes: ______________________

   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)? ______________________

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(cont.)

2. Company:____ Effective date of coverage:________________

Deductible: $____________ ❑ per person or ❑ per family? ❑ per fiscal year or ❑ per calendar year or ❑ per policy year? ❑ per diagnosis?

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

Benefit: ______% of ❑ charges ❑ Usual, customary, and reasonable (UCR) ❑ Maximum charge of $____

❑ Other benefits: ____

Percent reduction, if any, for mental health? ______%

Limitations: Number of visits: __________ Monetary limits: $______________ per ___________________

Lifetime limits $____________

Is outpatient group psychotherapy covered? ❑ Yes ❑ No

Must a physician refer the client? ❑ Yes ❑ No

Is psychological testing covered? ❑ Yes ❑ No

Does any rule about preexisting conditions apply here? ❑ No ❑ Yes: ______________________________

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

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

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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