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Financial Information Form

I truly appreciate you 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 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 office administrator.

A. Patient's name: _____ Birthdate:_____ Soc. Sec. #_____

Address: _____ Home Phone: _____

(If the patient is a dependent) Insured's/policy holder's name: _____

Email address: _____ 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 dif. from patient): _____

Policy #: _____ Certificate #: _____

Phone: _____ Provider's phone: _____

Address to send claims: _____

3. **Health maintenance organization (HMO)**

   Name of HMO: _____ Policy holder (if dif. from patient): _____

   Authorization #: _____ Agreement #: _____

   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 ☐ per family ☐ per fiscal year ☐ per calendar year ☐ 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? ☐ yes ☐ no If yes, explain

   _____

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

_____

_____

_____

2. Company: _____ Effective date of coverage: _____

   Deductible: $_____ ☐ per person ☐ per family ☐ per fiscal year ☐ per calendar year ☐ 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? ☐ yes ☐ no If yes, explain

   _____

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

   _____

   _____

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 changes, regardless of insurance coverage.

H. Assignments 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.