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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)? ____

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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)? ____

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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 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.