Financial Information Form

We truly appreciate your choosing to come to us for 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 or part of the cost of your treatment here. To find out if this is so, we need the information requested below. We can assistance you in getting the specific information regarding your benefits from your insurance. Then, when we have this information, we have to examine the treatment choices allowed by the coverage you have.

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

Please return this form as soon as possible.

Patient's name: _____ Birthdate: _____

Soc. Sec.#:_____Address:_____

Home phone: _____

(If the client is not the subscriber) Insured's/policy holder's name: _____

Birthdate: _____ Soc. Sec. #: _____

Address: _____ Home phone: _____ Occupation:_____

Employer: _____

Name of Insurance _____

Name of subscriber (if not the patient):

_____

Identification/agreement/policy #: _____

Group or enrollment #: _____

Plan #/code or BS #:_____

Effective date: _____

Location of plan: _____

Phone: _____

Copayment $____

Deductible: $ _____

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

Benefit: _____%

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