INSURANCE INFORMATION

You are responsible for confirming and obtaining authorization for health care benefits available to you. We are Licensed Professional Counselors, Marriage and Family Therapists, depending upon your therapist; Board Certified in Mental Health for practicing counseling and psychotherapy.

You are responsible for any charges such as deductibles and co-pays not covered by your health care plan or denied for any reason, for any interest charged and for late cancellation or no show charges. Interest of 1.5% per month (18% APR) is charged on balances due over 60 days.

PATIENT INFORMATION

Thank you for providing complete, accurate and legible information!

PATIENT NAME:_____MALE ___FEMALE___

PATIENT ADDRESS:_____

_____

PATIENT DATE OF BIRTH _____ SINGLE_____ MARRIED_____

PATIENT RELATION TO SUBSCRIBER: SELF_____ SPOUSE_____ CHILD_____ OTHER_____

SUBSCRIBER INFORMATION (or same)

SUBSCRIBER NAME:

_____

SUBSCRIBER ADDRESS: _____

_____

SUBSCRIBER DATE OF BIRTH _____ MALE _____ FEMALE_____

_____

NAME OF HEALTH CARE PLAN: _____

_____

ADDRESS: _____

_____

SUBSCRIBER ID# _____GROUP#_____

DEDUCTIBLE AMOUNT: _____ CO-PAY AMOUNT:_____

AUTHORIZATION NUMBER IF REQUIRED: _____

Your signature indicates agreement with the above terms, authorizes Counseling Associates, P.C. to furnish information necessary to process your claims, to receive information about your medical history and assigns benefits for payment directly to us.

Signature Date