Choices Counseling and Coaching

Financial Information Form

We truly appreciate your choosing to come to Choices for treatment. As part of providing high-quality services, we need to be clear with you 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, we need the information requested below in sections D, E, F and G. I will explain any part of this form that is not clear to you.

A. Please select one or more of the following options:

1. ❑ I intend to use any insurance benefits available to pay for part of the services I receive here. (Please complete sections E, F, and G of this form.)
2. ❑ I decline to use the health insurance I have with ______________________ (company). (Please select options 4, 5, or 6 below.)
3. ❑ I have no health insurance coverage.
4. ❑ I intend to use a health savings account (HSA), flexible savings account (FSA), or similar
5. ❑ I will use a credit card to pay my copays or other fees
6. ❑ I will pay by cash or check at each visit.

B. We will submit claims to your health insurance plan. If we have a contract with your plan, we are "in network" and must charge you only the fee that the insurer and we have agreed to. You will pay the full fee until your payments reach the yearly deductible of your health insurance. After that, you will pay only the copayment or "copay" for each time we meet.

C. The use of health insurance to pay for all or part of therapy involves many considerations. The major concerns include these:

- When an insurance company pays for part of your treatment, the company has a right to review your records, limit treatment, and deny claims for payment.
- If your insurance changes, you agree to provide us with an update as soon as possible. If you become eligible for additional or different insurance such as Medicare, you must inform me.
- This office will submit claims in a timely manner and will provide an update to you if the insurance company or MCO denies the claim.

D. Please give us this information as it appears on your insurance policy or card:

Your name: ________________________________ Date of birth: ________________
Home phone #: _______________________ Cell #: ___________________
Home street address: ____
City: ____________________________________ State: _______ Zip: _____________________
We will need a copy of your insurance card – both sides.

E. If you have a Health Savings Plan please put that information below:

Account Number: ____________________________________ Expiration Date: __________________________

CVC Code: ____

We will charge your account for unpaid balances after insurance has paid.

Authorized signature: ____ Date: ___________________

F. Any unpaid balance will be charged to a credit card. Please list the credit card you would like us to use.

Account Number: _______________________________ Expiration Date: _________________

CVC Code: __________________________

Authorized signature: ____ Date: _________

G. Release of information and assignment of benefits:

I, the client (or the policy holder), by my signature below authorize the release by this office of any information obtained during evaluations and treatment that is necessary to support and process any insurance claims, determine medical necessity, support any clinical or financial audits, or requests for additional sessions. I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the clinician or organization above. Medicare regulations may apply.

I understand that I am responsible for all charges, regardless of insurance coverage or other payments. I understand that I will be responsible to pay the full session fee if I fail to cancel my appointment at least three business days in advance.

A photocopy of this assignment is to be considered as good as the original.

____________________________________ ______________________________________ ____/____/____

Client's (or policy holder's) signature Printed name Date

My signature indicates my agreement to and accuracy of all of the statements above

Please bring your (or the policy holder's) health insurance card(s) with you to your first session.