

INSURANCE INFORMATION AND FINANCIAL AGREEMENT

Client Name _____ DOB _____ Phone _____

Address _____ Zip _____

PRIMARY INSURANCE INFORMATION: *(If possible, please contact your insurance company prior to your first visit to determine your outpatient mental health benefits)*

Insurance Company _____

Address/Zip _____ Phone _____

Name of Primary Insured _____ DOB _____

Insured's Identification # _____ Group # _____

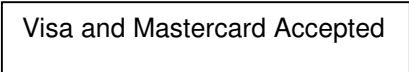
Insured's Address/Zip (if other than client's) _____

Employer Name or School Name _____

FINANCIAL AGREEMENT:

The fee per 50 min. session is: \$90 (individual) \$100 (couples)

Based on preliminary information from your insurance company:



Your insurance will pay _____ % or \$ _____ per session.

You have a deductible of \$ _____ which has/has not been met.

Your payment/co-payment is \$ _____ per session, to be paid in full at each office visit.

Comments: _____

CLIENT OR AUTHORIZED PERSON'S SIGNATURE:

I authorize the release of information necessary to process my insurance claims. I also authorize payment of any benefits from the insurance company(s) listed above to be paid to Rebecca Hauder, LCPC for services rendered by her.

I understand that all fees are my responsibility regardless of my insurance status and if insurance money cannot be collected, I am responsible for the amount due.

I am aware that I am responsible to pay for missed appointments and late cancellations (with less than 24 hours advance notice).

I understand that if my account becomes delinquent over 90 days and no payment schedule has been arranged with Rebecca Hauder's Office, the account will be turned over to a collection agency which may affect my credit report.

Client Signature _____ Date _____