BILLING INFORMATION

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Person Responsible for Session Fees

Complete If You Will Be Utilizing Insurance:

Primary Insurance Company:____

Customer Service Number:____

Name of Insured:___________________________________ Date of Birth:______________

Address of Insured:____

Employer: ____

ID Number: ______________________________ Group Number:________________

Secondary Insurance Company:____

Customer Service Number:____

Name of Insured:___________________________________ Date of Birth:______________

Address of Insured:____

Employer: ____

ID Number: ______________________________ Group Number:________________

Agreement: *I understand and agree to the following financial policy. I authorize the release of information necessary to process claims to my insurance company and authorize payment of mental health benefits for services provided. I accept financial responsibility for this account even if my insurance company fails to pay for services for whatever reason. I will be responsible to notify Dr. Hoffmann at least 24-hours in advance of any appointment I am unable to keep. I understand that there will be a $65 fee for all missed appointments without this notice.*

Signature:____ Date:___________________