

BILLING INFORMATION

Person Responsible for Session Fees

Complete If You Will Be Utilizing Insurance:

<p>Primary Insurance Company: _____</p> <p>Customer Service Number: _____</p> <p>Name of Insured: _____ Date of Birth: _____</p> <p>Address of Insured: _____</p> <p>Employer: _____</p> <p>ID Number: _____ Group Number: _____</p>

<p>Secondary Insurance Company: _____</p> <p>Customer Service Number: _____</p> <p>Name of Insured: _____ Date of Birth: _____</p> <p>Address of Insured: _____</p> <p>Employer: _____</p> <p>ID Number: _____ Group Number: _____</p>

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: _____