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 $75 fee for all missed appointments without this notice.*

Signature:_____ Date:_____