BILLING INFORMATION

_____

Person Responsible for Session Fees

Complete If You Will Be Utilizing Insurance or Write "N/A" if Private Pay:

Primary Insurance Company:_____

Customer Service Number:_____

Name of Subscriber on Policy:_____ Date of Birth:_____

Subscriber's Address: _____

Subscriber's Employer: _____

ID Number: _____ Group Number:_____

I certify that this is my primary insurance carrier:_____ (initial)

Secondary Insurance Company:_____

Customer Service Number:_____

Name of Subscriber on Policy:_____ Date of Birth:_____

Subscriber's Address _____

Subscriber's Employer: _____

ID Number: _____ Group Number:_____

Please note that I do not bill for secondary coverage but still need this information. _____ (initial)

Please be aware that it is your responsibility to promptly inform me if you change insurance companies or plan type. Failure to do so may impact coverage for your sessions, possibly creating more financial responsibility for you. _____ (initial)

Agreement: *I understand and agree to the following: 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 an $85 fee for all missed appointments without this notice and that my full fee will be charged after 3 late cancelations.*

Signature:_____ Date:_____