



P. ARMSTRONG, PH.D

Psychological Services
8632 S. Sepulveda Blvd., Ste. 200
Los Angeles, CA 90045
(310) 613-0829
(310) 337-7333 fax

FINANCIAL INFORMATION FORM

I truly appreciate your choosing to come to me for psychological help. As part of providing high-quality services, I need to be clear about our financial arrangements.

- If you have health insurance, it may pay for a part of the cost of your treatment here. To find out if this is so, I need the information requested below. I will explain any part of this form that you do not understand.
- If you have no health insurance coverage, or do not intend to use it, please check here , complete sections A and E below, and return this form to me.
- If I am not a provider on your health insurance coverage and you agree to pay my fee as a non-provider for your plan, please check here , complete sections A and E below, and return this form to me.

A. Client's name: _____ D.O.B.: _____ Soc. Sec.#: _____

Address: _____ Home phone: _____

(If the client is a dependent) Insured's/policy holder's name: _____

Employer: _____ Occupation: _____

Work phone: _____ Work Address: _____

B. (if applicable) Spouse's name: _____ D.O.B.: _____ Soc. Sec.#: _____

Employer: _____ Occupation: _____

Work phone: _____ Work Address: _____

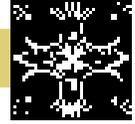
C. Please fill out the name and numbers for your insurance.

1. Name of subscriber (if different from patient): _____

Identification/agreement/policy#: _____ Group or enrollment #: _____

Plan #/code: _____ Effective date: _____

Provider's phone: _____



D. Insurance Verification (To be Completed by the Office)

Company: _____

Effective date of coverage: _____

Deductible: \$_____ per person or per family? per fiscal year per calendar year or per policy year? per diagnosis?

How much of this deductible has been used so far? _____

Benefit: _____% of charges Usual, customary, & reasonable (UCR)

Maximum charge of \$_____

Other benefits: _____

Percent reduction, if any, for mental health? _____%

Limitations: Number of visits: _____ Monetary limits: \$_____ per _____

Lifetime limits: \$_____

Is outpatient group psychotherapy covered? Yes No

Must a physician refer the client? Yes No

Does any rule about preexisting conditions apply here? Yes: _____ No

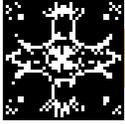
Are there any other limitations (such as conditions not covered, service settings, maximum per-session charges, need for DSM or ICD diagnostic codes or CPT service codes)?

E. If you do not have health insurance or I am not a provider on your health insurance plan, how will you pay for services? I will pay for services when rendered at then end of each session and

Dr. Armstrong will provide a monthly "Super Bill" that will be submitted for reimbursement.

F. I give Dr. Armstrong permission to release any information obtained during treatment for myself or my _____ that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.

G. I understand that I am responsible for all charges, regardless of insurance coverage.



H. Assignment of benefits

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to Dr. Armstrong. A photocopy of this assignment is to be considered as good as the original.

Client's (or parent/guardian's) Signature,
Including agreement to all of the statements above

Date

Printed Name