P. ARMSTRONG, PH.D

Psychological Services
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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