FINANCIAL INFORMATION FORM

(Clinician/Company Name and Information Goes Here)

Patient's name:_____ Birth Date: ____/____/____

Address: _____ Home Phone:_____

Occupation:_____ Employer:_____ Work Phone:_____

Spouse's name: _____ Birth Date: ____/____/____

Occupation:_____ Employer:_____

Health Insurance Carrier/Company

Name of company:_____

Name of policyholder (if not the patient):_____ Birth Date: ____/____/____

Policy #:_____ Certificate #:_____

Phone:_____ Address to send claims:_____

Limits to mental health benefits:_____

My copay/coinsurance is $: _____ per session

Name of Secondary Insurance Company

Name of company:_____

Name of policyholder (if not the patient):_____ Birth Date: ____/____/____

Policy #:_____ Certificate #:_____

Phone:_____ Address to send claims:_____

Limits to mental health benefits:_____

My copay/coinsurance is $: _____ per session

If you do not have insurance, how will you pay for services from this office? _____

I give this office permission to release any necessary information obtained during examinations or treatment of this patient to support any insurance claims on this account or to secure timely payments due to the assignee or myself.

I understand that I am responsible for all charges for services provided.

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to name of your Clinic Service.

_____ _____ ____/____/____

Signature of client (or parent/guardian/policy holder) Printed name Date

This form is intended as a model only. Please change to fit your needs. You should remove the header and footer (copyright) information from the final form.