FINANCIAL AGREEMENT

A.Client Information

Last Name: _____ First Name: _____ Middle Initial: _____
Social Security Number: _____
Date of Birth: _____
Address: _____ City: _____ State: _____
Zip: _____
Home Phone: _____
Alternate Phone (specify if work or cell): _____

Employment:

Employed Full-Time Student Part-Time Student

Other (specify) _____

Gender:

Name of Employer: _____

Employer Phone:_____ _____

Employer Address: _____ City: _____ State: _____Zip:

B. Insurance Information

Name of Person Responsible for Bill: _____
Date of Birth: _____
Relationship to the client: _____
Social Security Number: _____
Address (if different):_____
Home Phone: _____
Alternate Phone (specify if work or cell): _____

Name of Employer: _____
Employer Phone: _____
Employer Address: _____ City: _____ State: _____Zip: _____

Primary Insurance Information
Name of Insurance Company: _____
Policy #:_____
Subscriber's Name: _____
Subscriber's SSN: _____
Client's Relationship to Subscriber: _____
Co-pay amount: _____
Insurance Company Phone: _____
Effective Date: _____
Do you have a calendar year deductible? Yes ____ No ____
If so, how much have you met? _____
Do you have secondary insurance that covers services that your primary does not?

Yes_____
No _____

Secondary Insurance Information
Name of Insurance Company: _____
Policy #:_____
Subscriber's Name: _____
Subscriber's SSN: _____
Client's Relationship to Subscriber: _____
Co-pay amount: _____
Insurance Company Phone: _____
Effective Date: _____

C. Agreement

I understand that I am responsible for contacting my insurance company to verify and understand my insurance coverage. I agree to obtain preauthorization for counseling services, if my insurance company requires me to do so. Please be aware, that receiving authorization for services does not guarantee that your insurance company will cover the services you are receiving from Emily Berman, LPC. Your insurance company will determine if these charges will be covered at the time the claim is received. I understand that I am ultimately responsible for payment of my bill regardless of insurance.
I agree to update my therapist regarding any changes with my insurance coverage and allow my therapist to maintain a copy of my current insurance card. I authorize Emily Berman, LPC or my insurance company to release any confidential information required to bill and be paid for services. Furthermore, I authorize payment directly to my therapist and hereby assign my right to reimbursement to Emily Berman, LPC. Additionally, I agree to pay at the time of service all fees due, including insurance deductibles, insurance co-payments, late cancellation/missed appointment fees or any charges for returned checks.

I will:

____ Pay each visit in full and file my own insurance

____ Pay my insurance co-payments and any other fees each session and have my Insurance billed

____ Self-pay

I have read the above, understand, and accept the policies described herein. I certify that the above information is complete and accurate and understand all information is subject to verification by Emily Berman, LPC.
Signature of client (or person acting for client)

Date _____
Printed name _____
Signature of therapist_____
Date _____
___- Copy given to client ___ Copy kept by therapist