Laurie Furman, MS, MSW, LCSW
Furman Family Counseling, LLC
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Financial Information and Agreement Form for Insurance Clients

We truly appreciate your choosing to come to us for counseling services. As part of providing high-quality services, we 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, we need the information requested below.

A. Policy holder's name: _____
Date of birth: _____
Social Security number: _____
Address: _____
Home phone: _____ Cell phone: _____
Occupation: _____ Work phone: _____
Employer: _____ Address of employer: _____
_____

B. Client's name: _____
Date of birth: _____ Social Security number: _____
Occupation: _____ Work phone: _____
Employer: _____Address of employer: _____
_____

C. If you intend to use Employee Assistance Program (EAP) benefits, please complete the information below:
Name of EAP company: _____ Address:_____
_____ Phone number: _____
Employer contract: _____
Authorization number: _____ Number of sessions allotted: _____

D. Commercial health insurance carrier/company:
Name of company: _____Address: _____
_____Phone number: _____
Policy #: _____
Group #:_____ Effective Date: _____
Authorization #: _____ # sessions allotted: _____ Co-pay: _____
Claims address: _____
_____

E. Assignment of benefits

- I hereby authorize the release of any medical information necessary to process my insurance claim to my third party carrier.
- I authorize the release of any medical information to my referral source.
- I understand that when I elect to use my health insurance benefits to pay for psychotherapy services that my diagnosis, symptoms and substance abuse (if any) issues and history will become part of my permanent insurance records. My insurance company has retained the right to access and copy any and all of my record.
- I understand that my therapist may be required to fax or email treatment plans and diagnostic reports to my insurance carrier. I understand that in some instances, this

information may be submitted to insurance data bases and/or employers when they are the purchasers of my medical/mental health benefits.

- I understand that different co-payments or co-insurance payments are required by various group coverage plans. I acknowledge that my co-payment is based on the Mental Health Policy selected by my employer or purchased by me. In addition, I am aware that the co-payment may be different for the first visit than for subsequent visits. I acknowledge that if I have a deductible, I may also be responsible for the contracted rate until all of my yearly insurance deductibles have been met.

- I understand, that prior to my first visit, I am responsible for checking my insurance and EAP benefits including coverage, deductibles, preauthorization, number of sessions permitted, payment rates, co-payments and co-insurance.

- I understand that co-payments are collected at the time of service in the form of cash or check. If, at any time, a co-payment, statement, or preauthorization has been adjusted, I agree to notify my therapist. I understand that I will be required to pay the difference or will be given a credit if over billed. I understand that my therapist will make me aware of any credits or adjustments from the insurance company.

- I understand that if my insurance does not pay for services, I will be responsible for the balance due.

- I understand that if I need to cancel an appointment, I am required to provide notification **at least 24 hours** in advance or I will be billed directly for the **full cost** of my missed session. I understand that if I am using insurance, I will be charged the **CONTRACTED RATE** for the cost of my missed session (e.g., if the contracted rate for United Health Care is $65/session and my co-payment is $25, I will be charged $65 for the missed session). I understand that I may leave a message on the voice mail, which does have a time stamp and is checked after regular office hours.

- I hereby authorize payment of medical benefits to Laurie Furman, MS, MSW, LCSW of Furman Family Counseling, LLC for all of the services described on the attached form.

_____ _____

Signature of client (or person acting for client) Date
Indicating agreement to all of the statements above

_____

Printed name

PLEASE NOTE: INSURANCE COMPANIES WILL NOT PAY FOR MISSED APPOINTMENTS.

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