

# MIDWEST CENTER FOR PSYCHOTHERAPY AND SEX THERAPY

## Billing-Insurance Information Form

### For Office Use:

Therapist \_\_\_\_\_ DX \_\_\_\_\_ Date of Intake \_\_\_\_\_

### Client Information:

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

Social Security # \_\_\_\_\_ Relationship status \_\_\_\_\_ Student status: Full / Part-Time

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ - \_\_\_\_\_  
(4-digit)

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Ethnicity/Race (optional):  White/Caucasian  African-Am.  Asian  Latino/Hispanic  Native Am.  Multi-racial  Other \_\_\_\_\_

Do we have permission to **contact** you at this #? Do we have permission to **leave a message** at this #?

Yes No Yes No

Home # \_\_\_\_\_

Work # \_\_\_\_\_

Cell # \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone # \_\_\_\_\_

### **PARENT/GUARDIAN COMPLETES THIS SECTION IF CLIENT IS A MINOR**

Parent(s)/Guardian(s): \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

Social Security # \_\_\_\_\_ Relationship to client \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State & Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Home phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Cell Phone # \_\_\_\_\_

### **IF USING INSURANCE PLEASE COMPLETE THIS SECTION\***

**If you have additional insurance, please list on a separate sheet**

Primary Insurance Company \_\_\_\_\_ Name of Policyholder \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Circle coverage: Family / Individual

Group# \_\_\_\_\_ and/or Subscriber# \_\_\_\_\_ Policyholders SS# \_\_\_\_\_

Policyholder Address (if different from client) \_\_\_\_\_

Relationship to client \_\_\_\_\_ Effective Date of Coverage \_\_\_\_\_ DOB of Policyholder \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Name of Policyholder \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Circle coverage: Family / Individual

Group# \_\_\_\_\_ and/or Subscriber# \_\_\_\_\_ Policyholders SS# \_\_\_\_\_

Policyholder Address (if different from client) \_\_\_\_\_

Relationship to client \_\_\_\_\_ Effective Date of Coverage \_\_\_\_\_ DOB of Policyholder \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**\*Please present your photo ID for copying. If using insurance please give the policyholder's photo ID and insurance card to our office assistant, or your therapist, so copies are made for our billing office.  
(over)**

Midwest Center for Psychotherapy and Sex Therapy is certified by the State of Wisconsin as an Outpatient Treatment Facility. One requirement of certification is collaboration. Your therapist may consult with other therapists within the clinic regarding your treatment at specified times.

**Fees are determined by individual therapists. Your initial evaluation fee is \$ \_\_\_\_\_ ; your session fee is \$ \_\_\_\_\_.**

Copays are due at time of service. As a courtesy, we will file for reimbursement with the insurance company; **however, the ultimate responsibility for payment on the account is the client's or the client's parent/guardian. MCPST does not accept responsibility for collection of any claim or negotiating a settlement on a disputed claim.** The client will receive a monthly statement indicating all charges and payments. In the event the client or client's parent/guardian does not pay an outstanding balance, the client's account may be referred to a collection agency, which could lead to legal action.

A fee of \$30.00 will be charged on all NSF or returned checks.

When necessary to cancel an appointment, please do so at least 24 hrs in advance. Please leave a cancellation message directly in your therapist's confidential voice mail. The client or client's parent/guardian is personally responsible for any professional fee when an appointment is missed and/or not properly canceled, except in extenuating circumstances. Insurance will not reimburse for missed appointments. Our cancellation policy is posted for your information in our office and at [www.midwestcentertherapy.com](http://www.midwestcentertherapy.com).

**Detail any fee or payment arrangement below, if different from the above terms:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand and agree to these terms. *(please sign below)*

→ **Client (or parent/guardian)** \_\_\_\_\_ **Date** \_\_\_\_\_

Therapist \_\_\_\_\_ **Date** \_\_\_\_\_

### **IF USING INSURANCE PLEASE COMPLETE THE SECTIONS BELOW**

To simplify our accounting, we prefer insurance benefits to be paid by the insurance company directly to us. We would appreciate, therefore, you signing the Assignment of Benefits directive below.

#### **ASSIGNMENT OF BENEFITS**

I hereby authorize my insurance company to make payments directly to Midwest Center for Psychotherapy and Sex Therapy for psychotherapy services. I accept personal responsibility for the deductible amount and for any balance outstanding after payment of such benefits. I further understand that copies of this authorization will be used in subsequent billings and they be accepted as valid as the original. *(please sign below)*

→ **Client (or parent/guardian)** \_\_\_\_\_ **Date** \_\_\_\_\_

#### **AUTHORIZATION FOR RELEASE OF INFORMATION TO INSURANCE PROVIDERS**

I understand I am under no obligation to sign below and Midwest Center for Psychotherapy and Sex Therapy who I am authorizing to use and/or disclose my health information may not condition treatment or payment on my decision whether to sign this authorization.

- I authorize release of claim form information to all my insurance companies.
- I authorize release of treatment reports (written and/or verbal) as requested by my insurance company or managed care organization.
- I authorize use of this authorization on all my insurance submissions.
- I permit this signed authorization to be used in place of the original.

I understand I have the right to revoke this authorization at any time. I also understand my revocation of this authorization must be in writing. To obtain a copy of the authorization revocation form I may contact my treating therapist or any Midwest Center for Psychotherapy and Sex Therapy staff person. I am aware my revocation will not be effective if: (1) this authorization was obtained as a condition for obtaining insurance and applicable law permits the insurer to contest the claim or the policy itself; or, (2) to the extent the treating therapist and/or Midwest Center for Psychotherapy and Sex Therapy has already acted in reliance upon this authorization.

Name of policyholder *(please print)* \_\_\_\_\_ Subscriber number \_\_\_\_\_

→ **Signature of client** \_\_\_\_\_ **Date** \_\_\_\_\_

→ **Signature of Parent or Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_