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 #? Yes	No	Do we have permission to **leave a message** at this #? Yes	No
Home #______________________________	☐	☐	☐	☐
Work #______________________________	☐	☐	☐	☐
Cell #______________________________	☐	☐	☐	☐

Emergency contact ______________________________Relationship______________________________ 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 and Insurance card for copying**

(over)

Fees are determined by individual therapists. Your therapist's fee schedule is attached.
Fees may be slightly higher for Emergency Management. Fees for psychological evaluation, third party consultation, record review, and reports are not covered by insurance and may be charged separately.

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 if there is an outstanding balance or upon request. 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.

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

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I understand and agree to these terms and conditions, including having received a copy of therapy fees. *(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 will 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.

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Name of policyholder *(please print)* Subscriber number

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→ **Signature of client** **Date**

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