ID ☐
Insurance Card ☐

Office Initials _____

MIDWEST CENTER FOR PSYCHOTHERAPY AND SEX THERAPY
Billing-Insurance Information Form

Therapist _____ ***Date of Intake*** _____ ***Chart #*** _____ ***DX*** _____

Client Information:

Last Name _____ First _____ MI_____ Date of Birth _____

Legal Sex: M / F Preferred Pronouns_____ Social Security #_____

Address_____City_____ State _____ Zip _____ Student status: Part-Time

Relationship status _____ 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** _____Relationship_____ Phone #_____

GUARANTOR PARENT (s)/GUARDIAN (s) COMPLETES THIS SECTION IF CLIENT IS A MINOR

Parent/Guardian: _____MI_____ Date of Birth _____ Sex: M / F

Social Security #_____ Relationship to client _____ Contact phone #_____

Address _____ City_____ State & Zip_____

Parent/Guardian: _____MI_____ Date of Birth _____ Sex: M / F

Social Security #_____ Relationship to client _____ Contact phone #_____

Address _____ City_____ State & Zip_____

IF USING INSURANCE PLEASE COMPLETE THIS SECTION*
If you have additional insurance, please list on a separate sheet

Primary Insurance Company_____ **Name of Policyholder**_____

Group#_____ **and/or** Subscriber#_____ Policyholders SS#_____

Policyholder Address (if different from client) _____

Relationship to client _____ Effective Date of Coverage _____ DOB of Policyholder _____, _____, _____

Secondary Insurance Company_____ **Name of Policyholder**_____

Group#_____ **and/or** Subscriber#_____ Policyholders SS#_____

Policyholder Address (if different from client) _____

Relationship to client _____ Effective Date of Coverage _____ DOB of Policyholder _____, _____, _____

***Please present your photo ID and Insurance card for copying**

(over)

Fees are determined by individual therapists. Your therapist's fee schedule is attached. Clients are responsible for all fees, services, and diagnoses not covered by their insurance. MCPST does not guarantee coverage for services.

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.

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

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 _____

* Signing or typing your name here constitutes a signature.

AUTHORIZATION FOR RELEASE OF INFORMATION TO INSURANCE PROVIDERS

- I authorize and understand the release of claim form information to all my insurance companies or managed care organization.
- I authorize and understand the release of treatment reports (written and/or verbal) that may be requested by my insurance company or managed care organization.
- I authorize and understand the use of this form as authorization for 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.

I understand I am under no obligation to sign below and authorize Midwest Center for Psychotherapy and Sex Therapy to use and/or disclose my health information however by not signing I am taking full responsibility for payment of treatment.

_____ _____

Name of policyholder *(please print)* Subscriber number

* Signing or typing your name here constitutes a signature.

→ **Signature of client** **Date**

* Signing or typing your name here constitutes a signature.

→ **Signature of Parent or Guardian** **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. Your signature is required below to authorize this.

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)** _____ _____

* Signing or typing your name here constitutes a signature.