INSURANCE FORM

TO BE COMPLETED BY CLIENT ON INTAKE, OR WHEN A POLICY IS CHANGED

Client Information

Child's Full Legal Name:

Nickname or Preference in Address:

Child's Date of Birth MM/DD/YYYY):

Gender: ☐ Male ☐ Female

Child's Social Security Number:

Address:

Are you a new client? ☐ Yes ☐ No Referred By:

Child's Primary Care Provider:

Name of Mother or Guardian:

Address:

Home Phone: Cell Phone:

Email Address:

Name of Father or Guardian:

Address (if different from above):

Home Phone: Cell Phone:

Email Address:

Today's Date (MM/DD/YYYY):

Subscriber Information (Primary Insurance Holder)

Subscriber's Full Legal Name:	
Relationship to Client:	
Address:	
Home Phone:	Cell Phone:
Work Phone:	Alternate Phone:
Subscriber's Date of Birth (MM/DD/YYYY):	
Subscriber's Social Security Number:	
Employer's Name:	
Occupation:	

Coverage Information

Name of Insurance Company:	
Address:	
Phone:	Fax:
Plan Name:	
Group Number:	
Policy Number:	
Coverage Effective Date (MM/DD/YYYY):	

(Please have your subscriber ID card ready for us to photocopy. Thank you!)

Today's Date (MM/DD/YYYY):

Assignment of Benefits

I hereby assign medical payments to include major medical benefits to which I am entitled, private insurance and any other health plan to ***The Learning Fountain, Inc.*** *for services provided by* ***The Learning Fountain Inc. Group****.*

I understand if claims are denied due to eligibility status, invalid medical group or invalid Primary Care Physician, I will assume full responsibility for all charges incurred by me and all dependents. Additionally, I will be financially responsible for any non-covered benefits, deductibles or any co-payments for services, which have been provided to me.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Signed: Date (MM/DD/YYYY):

INSURANCE/CASH PAYMENTS

Clients are financially responsible for services provided and are expected to pay at the time of service. We will courtesy bill your insurance; however, you will need to provide complete billing information at the time of your visit. A copy of your charges, if requested, will be supplied to you so that you may follow up with your insurance company personally.

HMO/PPO CLIENTS

If you are a member of a HMO/PPO you are required by your health plan to pay a co-payment at the time of your visit. We cannot waive the co-payment amount as a contracted provider. Co-payments will be collected at the time of service. Non-covered services must be paid at the time of service.

LATE/CANCELLATIONS/NO SHOWS

If you arrive late for your appointment, your therapist will be notified. It will be up to the therapist to decide if they are still able to complete your visit, or if you will need to reschedule your appointment.

If you have a scheduled appointment and are unable to keep your appointment, please contact our office as soon as possible to cancel your appointment. ***Please note:** if you cancel or reschedule with less than 8 business hours notice (8business hours = 1 business day), you will be charged a fee.

A missed appointment is recorded in your chart unless it is cancelled in advance, otherwise a fee will be charged. To **Regional Center** Clients - it is within the therapist's discretion to discharge you from the program if you've had repeated cancellations or no-show appointments (at least 3 consecutive cancellations or no shows).

CHARGES FOR COMPLETION OF FORMS, PHOTO COPYING OF THERAPY RECORDS

There is a charge for completion of forms and photo copying medical records.

PAYMENT METHOD

For your convenience, we accept cash and personal checks.
Please make your checks payable to: **The Learning Fountain, Inc.**
A $25.00 charged will be applied on all returned checks.

I acknowledge that I have read and understand the above financial policy.

Signed: Date (MM/DD/YYYY):