Financial Agreement and Insurance information

When billing insurance companies for service it is often unclear exactly what the benefits will be. Please list the person responsible for payment not received from the insurance company. If you are not the primary insured, please list their information.

o Client o Primary insured o No insurance

Name _____ and DOB (date of birth)_____

Address (if other than client)_____

Insurance: name/plan _____

ID # _____ Group #_____

Co-pay: _____ Deductible _____

Initial each of these:

___I authorize the co-pay, deductible, or complete payment at time of service by bankcard. Bankcard transactions may be processed the day of service or prior to the last day of the service month.

___I authorize Sheila Weisbrod, LPC, to provide information to my insurance company for the purpose of payment.

___I authorize my insurance company to pay benefits directly. I authorize charges not paid by my insurance company (copay and deductibles) to be charged on this bank or debit card.

___I authorize a charge for missed appointments or not canceling 24 hours in advance of my scheduled appointment time. (Illness and emergencies accepted)

Card #_____ Exp _____

Security code (3 digits on back of card) _____ ZIP code_____

_____ _____

Signature **Date**

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