Financial Authorization and Assignment Form

CLIENT NAME: _____ ☐ Male ☐ Female
Last First Middle

DATE OF BIRTH: _____/_____/_____ ADDRESS:_____

CITY: _____ STATE: _____ ZIP:_____

HOME TELEPHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____

EMAIL ADDRESS: _____
(Optional)

RESPONSIBLE PARTY INFORMATION

RESP. PARTY NAME: _____ ☐ Male ☐ Female
Last First Middle

RELATIONSHIP TO CLIENT: _____ DATE OF BIRTH: ___/___/_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____

HOME TELEPHONE: (_____) _____-_____ WORK TELEPHONE: (_____) _____-_____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

POLICY HOLDERS NAME: _____

RELATIONSHIP TO CLIENT: _____ SSN#: ____/____/____

DATE OF BIRTH: ____/____/____ POLICY #:_____

GROUP #:_____

SECONDARY INSURANCE: _____

POLICY HOLDERS NAME: _____

RELATIONSHIP TO CLIENT: _____ SSN#: ____/____/____

DATE OF BIRTH: ____/____/____ POLICY #:_____

GROUP #:_____

CREDIT CARD INFORMATION (PRIVATE INSURANCE AND OUT OF POCKET CLIENTS)

NAME ON CARD:_____ CARD #:_____
3 DIGIT SEC CODE:_____ EXP DATE:_____ ZIP CODE:_____

I_____ hereby authorize to furnish to any insurance organization having coverage in force on the client, any information (including but not limited to the patient's medical records), necessary for administering such coverage.

Read and Initial

_____If my insurance requires pre-authorization for treatment, I understand and agree that I am responsible for obtaining authorization prior to receiving counseling.

_____I understand and agree to pay copay/coinsurance/deductible at time of service. When payment is not made at time of service, payment is expected within 30 days of date of service. If payment is not made within that timeframe a $15.00 late penalty will be added, and interest will accrue at the rate of 1.5% per month.

_____I understand and agree that I am financially responsible to Replay Counseling Center, LLC for charges not covered by insurance and agree to payment of same within 30 days of notification of insurance denial.

_____ I understand and agree that Reply Counseling Center, LLC is authorized to bill my copay/coinsurance/deductible through the credit card I provide on file as agreed upon.

_____I understand and agree that accounts in default are subject to be turned over to a collections agency, which will result in an additional fee of 33.3% of the total balance.

_____I understand and agree that any payments due to Replay Counseling Center, LLC will not be bankrupted or claimed on any petition to a bankruptcy court or proceeding for credit relief. If such relief is sought, client agrees to reaffirm this debt and pay any costs or fees associated with legal action to enforce this agreement.

_____I understand and agree to pay a $45.00 for late cancellation (less than 24 hours) or no show on scheduled appt.

_____I understand and agree that I am financially responsible for a $35.00 returned check fee if my check is returned for insufficient.

_____I understand and agree that records releases, reports, letters, and telephone calls are billed based on time required to complete activity as shown in the fee schedule below. Payment is due at the time the service is provided.

Fee Schedule

Initial Diagnostic Interview – 45-50 minutes	$100.00
Psychotherapy (individual, couple and family) – 50 minutes	$90.00
Play Therapy	$90.00
Preparation of reports, letters, telephone or other conferences, Records releases – per 15 minutes – not covered by insurance	$25.00
Therapeutic Art	$55.00
All forensic Services per hour (including but not limited to court Testimony, disposition, conferences, preparation of reports, travel and records review. – Per hour – not covered by insurance	$300.00

_____ _____

SIGNATURE (Parent's signature if client is a minor) DATE