FAMILY & CHILD DEVELOPMENT

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CLIENT INFORMATION

Name: ____
First   Last

Address: ____

City: ____________________ State: ______________ Zip: ____________

Home Phone: ________________ Work: ______________ Cell: ____________

Date of Birth: ________________ Social Security Number: ______________

Email: ____

Please circle one: Married   Divorced   Single   Widow   Child

How were you referred to our practice? _____ Internet   _____ Friend   _____ Phone book

_____ Insurance company   _____ other ______________________________

INSURANCE INFORMATION

Primary Insurance Information:

Name of Insured Policy Holder: ______________________________________

Name of Insurance: ______________________________________

Contract Number: ____________________ Group Number: ______________

Military One Source Authorization Number: ______________________________

Begin Date: ____________________ Expire Date: ______________

Number of Sessions: ____________________ Provider: ______________

Secondary Insurance Information:

Name of Insured Policy Holder: ____

Name of Insurance: ____

Contract Number: ______________________ Group Number: ______________

General Information Regarding Insurance:
Medical insurance coverage is a contract between you and your insurance company. Neither FCD nor your therapist is a party to your contract, and has no standing in any disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary.

If you have medical insurance, we are happy to file initial claims on your behalf to your medical insurance company for the services that are provided by our office. It is important that you understand that we are typically required to provide a diagnosis to your insurance company in order to be paid.

To help us process your claim correctly, please make sure that the information you provide to our office on the patient information form remains accurate and current. If there is a change in your insurance information, it is your responsibility to let us know immediately. We will submit secondary insurance if you indicate that you want us to perform this service on your behalf.

A SPECIAL NOTE Situations such as separation or divorce can affect your insurance coverage, and it is your responsibility to let your therapist know about this kind of development.

Deductibles, Co-Payments, and Coinsurance:
Co-payments are due at the time the service is rendered. Coinsurance and deductibles vary for each insurance policy, and we can only approximate the percentage covered by each plan. Payment of the estimated portion is due at the time of service.

Authorizations:
A copy of your insurance card is required at the time of the initial service. The card is descriptive and indicates whether an authorization is needed. Oftentimes, the behavioral health benefits are under a separate company, and we must contact them to verify the necessity of an authorization. If a copy of the card is not on the file at the initial service and the claim is denied for "no authorization," you will be responsible for the payment

Whether you are using insurance or are self-pay, please understand that you are ultimately responsible for any payments or outstanding bills. Accounts that are past due will be turned over to our collection agency and may be reported to credit bureaus. We are committed to providing you with the best possible care, and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility.

I acknowledge that I have read and agree to the above Financial Policy.

______________________________ ______________________

Client or Responsible Party's Signature Date

CANCELLATION/MISSED APPOINTMENT AGREEMENT

Family and Child Development has a 24-hour cancellation policy. In the event that you do not call to cancel your appointment within 24 hours of your scheduled appointment, and you fail to show up for your appointment, you will be charged accordingly by your therapist. For example, your therapist may charge a penalty fee for a late cancellation or broken session, or you may be billed for the entire session.

OTHER SERVICES PROVIDED BY FCD

Please be aware that most insurance companies will not cover services such as court appearances, report preparation, record copying, etc. If you anticipate needing this type of service, discuss it with your therapist, and please be aware that you may incur unreimbursed expenses.

HIPPA COMPLIANCE

Family and Child Development has a policy that meets government standards for HIPPA (Health Insurance Portability and Accountability Act) which covers privacy of all medical information. If you desire to read or have a copy of our privacy policy please request this.

My signature indicates that I have been offered a copy of the Privacy Policy and gives this practice the right to file, on my behalf, for insurance payments.

____________________________________ _________________________

Client or Responsible Party's Signature Date

Family & Child Development
Credit Card Pre-Authorization Form

I authorize Family and Child Development to keep my signature on file and charge my credit card as follows:

_____I understand that my credit card number will remain on file for the duration of my treatment. Should there be a change in the card to be charged, it will be my responsibility to provide a new number immediately. My card will be charged the reserved day of service, and/or should I no-show for my scheduled appointment time.

_____As noted upon intake, a 24+hour notice is required in order to avoid being charged. The charge will be either for the co-payment amount or a late penalty fee. Any no-show may be charged the full rate which the insurance company will not cover. The only exception that would be given would be in the event of an emergency, of which there would be no charge.

Please initial above, complete card information below and sign. Thank you.

Credit Card Type_____________Visa____________MasterCard____________Discover

Account#____

Exp. Date: ___________________________Security Code__________________________

Cardholder Name: ____

Billing Zip Code: ____

X____
Signature of Client or Guardian, if under the age of 18

Date: _______________________

FOR OFFICE USE ONLY: ____

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