Touchstone Counseling & Coaching
105 Commons Way *Greenville, SC 29611
Phone: (864) 451-2258
www.touchstone-counseling.org

Financial Agreement

We truly appreciate your choosing to come to us for counseling services. As part of providing high-quality services, we need to be clear about our financial arrangements.

• If you have health insurance, it may pay for a part of the cost of your treatment here. To find out if this is so, my staff and I need the information requested below. We will explain any part of this form that you do not under-stand.

• If you have no health insurance coverage, or do not intend to use it, please check here ❑, complete sections A and E below, and return this form to me or my secretary.

A. Patient's name: _____ Birthdate: _____Soc. Sec. #: _____

Address: _____Home phone: _____

(If the patient is a dependent) Insured's/policy holder's name: _____

Occupation:_____Employer: _____ Work phone: _____

Address of employer:_____

B. (If applicable) Spouse's name: _____Birthdate: _____ Soc. Sec. #: _____

Occupation:_____Employer: _____ Work phone: _____

Address of employer:_____

C. If you (or your spouse) have any of these kinds of insurance, please fill in the numbers and names for each one.

1. Blue Cross/Blue Shield

Name of subscriber (if not the patient): _____

Identification/agreement/policy #: _____Group or enrollment #: _____

Plan #/code or BS #: _____ Effective date: _____

Location of plan: _____ Reciprocity #: _____

Phone: _____ Other information: _____

2. Commercial health insurance carrier/company

Name of company: _____

Name of policyholder (if not the patient): _____

Policy #: _____ Certificate #: _____

Phone: _____ Address to send claims: _____

3. Health maintenance organization (HMO)

Name of HMO: _____ Policy holder (if not the patient): _____

Authorization #: _____ Agreement #: _____

Phone: _____ Address to send claims: _____

(cont.)

4. Medicaid

List all numbers with any letters: _____

Note: Copayments by you are required.

5. Medicare Agreement

List all numbers with any letters: _____

Railroad Medicare/Mine Workers Medicare: _____

6. Workers' compensation insurance

Name of company: _____Policy #: _____Certificate #: _____

Address to send claims: _____

Phone: _____ Treatment authorized by: _____Date of injury: _____

6. Do you or your spouse have any other insurance coverage that applies here (Tricare, motor vehicle in-surance for an injury, etc.)? If yes, check here ❑ and fill in an empty section above.

7. Limitations: Number of visits: ___ Monetary limits: $ _____ per _____ Lifetime limits: $ _____
Is outpatient group psychotherapy covered? ❑ Yes ❑ No

Must a physician refer the client? ❑ Yes ❑ No

Is psychological testing covered? ❑ Yes ❑ No

Does any rule about preexisting conditions apply here? ❑ No ❑ Yes, and the rule is: _____

Are there any other limitations (such as conditions not covered, service settings, maximum per-session charges, need for DSM or ICD diagnostic codes or CPT service codes)? _____

_____

_____

E. If you do not have insurance, how will you pay for services from this office? We accept debit/credit cards, cash, checks, health savings account cards with Visa/Mastercard logo._____ _____

F. I give this office permission to release any information obtained during examinations or treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.

G. I understand that I am responsible for all charges, regardless of insurance or Medicaid/Medicare coverage.

H. Assignment of benefits

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the therapist above. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.

_____ _____

Client's (or parent/guardian's) signature, indicating agreement to all of the statements above — Date

_____

Printed name