PATIENT AND EMPLOYEE INFORMATION

PATIENT'S FULL NAME: _____
First Middle Last D.O.B.

PATIENT'S ADDRESS: _____
City State Zip

Home Phone: _____ Work Phone: _____

SOCIAL SECURITY NUMBER:_____ MARITAL STATUS:_____

Financially Responsible Party: ☐ Self ☐ Other

Name: _____ Age: _____ D.O.B. _____

SS# _____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____

Address: _____
City State Zip

Primary Insurance Company: _____

Insured's Name: _____
First Middle Last D.O.B.

Insured's ID #: _____ Insured's Group #: _____

Insured's Employer: _____Account #_____

Insurance Company Address: _____
City State Zip

Insurance Company Phone #: _____ Annual Deductible Amount: $_____

Deductible Met? ☐ Yes ☐ No Co-Pay Amount: $_____ EAP Sessions? ☐ Yes ☐ No

Pre-Authorization Required? ☐ Yes ☐ No AUTHORIZATION #: _____

Secondary Insurance Company: _____

Insured's Name: _____
First Middle Last D.O.B.

Insured's ID #: _____ Insured's Group #: _____

Insurance Company Phone #: _____

Patient's Name: _____

PAYMENT/INSURANCE AGREEMENT& AUTHORIZATION TO SEND REIMBURSEMENT INFORMATION

I accept responsibility for payment of charges for services rendered to the above named patient. I understand that full payment and/or my copayment and/or deductibles are expected at the time services are rendered unless Jewish Family Service agrees otherwise. (I understand that, unless the above named patient has coverage under a managed health plan (e.g., HMO, PPO, EAP, etc.) to which I subscribe and in which Jewish Family Service is a participating provider, I am personally responsible for the payment of all charges.) I understand that, as a courtesy, Jewish Family Service will file insurance claims for the services provided. However, this does not release me of my responsibility for payment of the charges for services. Payment for any charges denied or not covered by my insurance company becomes my responsibility and I agree to pay these charges.

I also understand that any court order I have is an agreement between the courts and me, NOT Jewish Family Service, and I am still responsible for payment of all charges. I understand and agree that I may be charged for and required to pay for missed appointments not cancelled at least 24 hours in advance. I further understand and agree that a collection agency and/or the courts may be used in the event of delinquent payment, and I realize that such action could require that Jewish Family Service release to the collection agency, attorneys, and/or the courts, information which identifies the parties involved, gives the patient diagnoses, and describes the dates and nature of the charges, as well as all other information contained on any claim filed. In addition, if I have requested that Jewish Family Service file the charges to my insurance company, I understand that securing benefits under health insurance or other health plans will require that Jewish Family Service provide the plan management with confidential patient information, including diagnosis and the dates and type of service rendered. Further, I understand that for utilization review, quality assurance, and other claims review purposes, it may sometimes be necessary for Jewish Family Service to provide the plan management with additional information concerning case history, presenting problems, treatment plans, prognosis, and other case information. I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health care claims made by or on behalf of the above named patient. This consent shall remain in effect until all claims have been fully processed and all review procedures completed. I understand that it is my responsibility to notify my therapist immediately of any changes in information.

_____

Signature of Adult Client or Parent/Legal Guardian Date

SLIDING FEE SCALE: Jewish Family Service offers a sliding fee scale to individuals and families who are financially unable to pay the full hourly rate of $120.00 per hour. This scale is based on the family's gross annual income, size, and other significant financial considerations. I have given my therapist the income documentation necessary to establish a sliding fee rate. I agree to the terms of this agreement. All fees are collected on the date of service. FEE: $_____ The adjusted fee will be re-evaluated annually, or sooner, if circumstances change.

_____

Signature of Adult Client or Parent/Legal Guardian Date

_____

Signature of Authorized JFS Staff Person Date