FINANCIAL INFORMATION FORM

PAYMENTS ARE DUE AND PAYABLE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. If you have health insurance, it may cover a part of the cost of your treatment. To determine this, we need the following:

Patient Name:_____ Birthdate:_____ Soc. Sec. #:_____

Address:_____ City & State: _____ Zip:_____

Home Phone #:_____ Business Phone #: _____ Cell #: _____

Email Address: _____ Can we email you at this address regarding billing questions?_____

Policy Holder's Name: _____ Birthdate:_____ Soc. Sec.#:_____

Policy Holder's Address (if different): _____

Insured's Employer: _____ Phone Number: _____

Relationship to Patient: _____ Do you have secondary insurance? _____

Source of Referral: ___ patient of Dr. Kaeppner ___ insurance company ___ website ___ other (specify)

Insurance Information – Before coming to your first visit, please look on the back of your card for information on "mental heath" or "outpatient psychotherapy" benefits. ***Please call your insurance company*** **and complete the information in this box with their help.**

Mental Health Insurance Carrier (Primary) _____

Policy or ID #: _____ Group #: _____ Effective Date: _____

Authorization #: _____ # of Sessions Authorized: _____ Co-pay per Session: _____

Dates Beginning and End of Authorization: _____ Mental Health Deductible: _____

Address to Where Mental Health Claims Should Be Sent: _____

_____

Mental Health Insurance Phone Number to Verify Benefits: _____

- REGARDING INSURANCE: Please advise us immediately of any changes in your insurance coverage during the course of your treatment. It is your responsibility to obtain any necessary authorizations/precertifications prior to treatment. Failure to do so may result in non-payment or reduced benefits, and you will then be responsible for full payment of the charges.
- COPAYMENTS should be made at the time of service, made payable by cash or check. There will be an additional $25 fee for each check returned by the bank for insufficient funds. Phone consultations longer than 10 minutes will be charged at a rate of $3 per minute, and are not reimbursed by insurance.
- MISSED APPOINMENTS / LATE CANCELLATIONS: Unless cancelled at least 48 hours in advance, we charge for missed appointments/late cancellations. The charge will be the full fee for that session, since insurance companies do not cover missed sessions. If you need to reschedule your appointment, please call us as soon as possible so that we might allow another client to take your scheduled time.
- FINANCIAL RESPONSIBILITY: You are financially responsible for all co-payments, deductibles, and full and timely payment of services if your insurance company has not paid within 60 days.
- CONSENT TO RELEASE INFORMATION TO INSURANCE: You authorize this office to release information about your condition and treatment to your mental health insurance carrier for reimbursement.
- DIRECT PAYMENT OF INSURANCE: You authorize your insurance company to reimburse this office directly.
- We will keep a credit card on file following the first appointment. This credit card will be used for any account balance due for a period longer than 3 weeks, unless prior written arrangements have been made and agreed upon by the office. Failure to cancel an appointment 48 hours in advance as per written office policy will result in a charge for that missed appointment to the same credit card unless prior written arrangements have been made and agreed upon by the office.

_____ _____

Signature of Patient or Guardian Date