becker/gibeau

Financial Agreement and Insurance Information

Name: _____ **Date of Birth:** _____

Doctor/Therapist: _____

Primary Insurance: _____

Insured's Name: _____ Insured's Date of Birth: _____
Insured's Address: _____
Insured's City: _____ State: _____ Zip Code: _____
Insured's Phone Number: _____

Insured's Social Security Number: _____ Insured's Gender: ☐ Male ☐ Female

Insured's Policy Number: _____

Insured's Relationship to Client: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance: _____

Insured's Name: _____ Insured's Date of Birth: _____
Insured's Address: _____
Insured's City: _____ State: _____ Zip Code: _____
Insured's Phone Number: _____

Insured's Social Security Number: _____ Insured's Gender: ☐ Male ☐ Female

Insured's Policy Number: _____

Insured's Relationship to Client: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Insured's Employer: _____

Employer's Address: _____

☐ I understand that having health insurance is not a guarantee that my condition is covered and that insurance payment will be made.

Financial Agreement (as of January 1, 2021) You can discuss a self-pay option with your therapist.

Standard Fees and Charges per Hour (Licensed Psychologist Level):	
Individual and Family Therapy, 16-37 minutes:	$150
Individual and Family Therapy, 38-52 minutes:	$175
Individual and Family Therapy, 53-60 minutes:	$200
Mental Health Assessment, 60 minute intake:	$250
Mental Health, Group Therapy, 90 minutes:	$125
Psychological Testing, 60 minutes: *Price may vary based upon test type & battery performed; please check with your provider for an exact rate.	*

Standard Fees and Charges per Hour (LPC Level):	
Individual and Family Therapy, 16-37 minutes:	$135
Individual and Family Therapy, 38-52 minutes:	$160
Individual and Family Therapy, 53-60 minutes:	$190
Mental Health Assessment, 60 minute intake:	$225
Mental Health, Group Therapy, 90 minutes:	$90

Agreement to Pay:

- I understand that I am financially responsible to my provider for services rendered.
- I agree to pay the co-pay, coinsurance, and any deductible stipulated by my insurance plan.
- Payment is due at the time of my appointment unless other arrangements have been made.
- It is my responsibility to inform my provider of any changes that affect the billing or charges to my account. This includes third-party payers, income, or family status.
- I understand that standard collection procedures will be followed if payment is not made.
- **Initial for Above Statements:** _____

Assignment of Benefits:

I authorize payment by my third party payer (Insurance Company, Medicare/Medicaid, County, or other) to be paid directly to BGPS for services rendered. I understand that I am financially responsible to BGPS for charges applied to deductibles and for all charges limited by my third party payer.

_____ _____

Signature of Individual Receiving Services/Legally Responsible Person Date

_____ _____

Staff Signature Date