DragonFly Counseling, PLLC

Financial Information Sheet/Insurance Information

Client Name_____ Birth Date_____ Gender_____
MM DD YY

Guardian Name (please print)_____

Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐ *Client Status*: Single ☐ Married ☐ Other ☐

Client Address_____
Street City State Zip

Cell Phone Number_____ Ok to leave message? Y/N Ok to text? Y/N

Work Phone Number_____ Ok to leave message? Y/N

Home/Other Phone Number_____ Ok to leave message? Y/N

Email Address: _____ Ok to email? Y/N

Emergency Contact _____ Relationship to insured _____

Emergency Phone _____

Insured's Name_____ Birth Date _____ Gender: _____
Please Print exactly as it appears on your Insurance Card MM DD YY (Circle One)

Insured's Address: _____ Home Phone Number_____
(Only list if different from client) _____ Work Phone Number_____

Primary Insurance: _____ Policy Number _____

Deductible $_____Amount met $_____ Copay $_____ Coinsurance % _____

Does the client have secondary insurance coverage? Y/N If yes, please fill out information on back of the form

EAP: Yes No EAP provider: _____Number of sessions: _____

How did you hear about DragonFly Counseling, PLLC? _____

I, as a Client or Insured Family Member, give consent and acknowledgement that this and other client information will be released to Insurance Carriers that provide financial reimbursement for requested services at Compass Mental Health:

_____ _____
(Client) (Date)

_____ _____
(Insured Family Member) (Date)

DragonFly Counseling, PLLC

Only fill out if there is secondary insurance coverage

Secondary Insurance: _____ Policy Number: _____

Secondary Insured's Name_____ Birth Date: _____ Gender: _____
Please Print exactly as it appears on your Insurance Card

Secondary Insured's Address: _____
Street City State Zip

Home Phone Number_____ Work Phone Number_____

Relationship to client: _____

Other payment amount due per 50 minute session _____
Provider's Initials _____ Date_____

INSURANCE

DragonFly Counseling accepts certain insurance and processes the claim with your insurance company. Co-pays are due at the time of service and patient is responsible for managing payments for services through their insurance carrier. I utilize an outside billing service, Blount Medical Billing who will be handling insurance claims, balance due services, collection action and all other services pertaining to billing.

PAYMENT OF BALANCE DUE

I will pay the full amount of charges for all services rendered which are not paid. I understand that termination of services will occur automatically upon the 4th session in which non-payment has occurred unless other payment arrangements have been made. If needed, an agreed payment plan may be created and entered into by said counselor and the financial responsible party until the debts are paid in full.

CREDIT BALANCES

Any credit balance on my account will be used to offset charges for future services for the above named client or applied to a current balance for any other clients of Trina Fry, LCPC for whom I am the responsible party. Any credit balance remaining at the end of treatment will be refunded to the financial responsible party.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

In the case that your out-of-network deductible has been met and you would like for me to submit a claim on your behalf, authorization is hereby given to release to my health care plan or insurance company or companies, or to any of its contracted/designated agent, any and all medical information essential to certify the medical necessity and appropriateness of services rendered, and/or to process any claim for reimbursement of charges incurred for services rendered or for the purpose of determining continued eligibility and/or audit for quality of care.

AUTHORIZEATION AND CONSENT TO THE TERMS INDICATED

I, THE UNDERSIGNED HEREBY CERTIFY THAT I HAVE READ AND UNDERSTAND THIS FINANCIAL AGREEMENT REGARDING ASSIGNMENT, AUTHORIZATION, AND DELAY OF PAYMENT. I HEREBY AUTHORIZE AND CONSENT TO THE TERMS INDICATED.

Financially Responsible Party (please print) _____

Signature_____ Date_____

_ _

Payment Information for Card on File, Acceptable form of payments include; Cash, Check, Credit and Debt

For ongoing credit and debit payments:

Name as it appears on card: _____ Amount of Payment: _____

Card#: _____ Exp. Date:_____ CVV:_____ Zip Code: _____