Suzette Wasvick Counseling Services, Inc

PO Box 763
280 Main Street, Suite 14
Hill City, SD 57745
Office: 605.390.8791

403 National Street, Ste 1
Rapid City, SD 57702
Office: 605.390.8791

Financial Information Form

I truly appreciate your choosing to come to me for treatment. As part of providing high-quality services, I need to be clear with you 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, I need the information requested below in sections D, E, F and G. I will explain any part of this form that is not clear to you.

A. Please select one or more of the following options:

☐ 1. I intend to use any insurance benefits available to pay for part of the services I receive here. (Please complete sections E, F, and G of this form.)

☐ 2. I decline to use the health insurance I have with _____(company). (Please complete sections E, F, and G of this form.)

☐ 3.I have no health insurance coverage.

B. If you ask me to, I can submit claims to your health insurance plan or managed care organization (MCO) for you, but you must authorize me to receive any payments the insurer makes. Because I have a contract with your plan, I am “in network” and must charge you only the fee that the insurer and I have agreed to. You will pay me the full fee until your payments reach the yearly deductible of your health insurance. After that, you will pay me only the copayment or “copay” for each time we meet.

C. The use of health insurance to pay for all or part of therapy involves many considerations. The major concerns include these:

- When an insurance company pays for part of your treatment, the company has a right to review your records, limit treatment and deny claims for payment.
- Not all services may be covered, including phone meetings, videoconferencing, and any services the company decides are not “medically necessary.” If you request and agree to services that are not covered, you will be expected to pay for them and we will sign an additional contract.
- If your insurance changes, you agree to provide me with an update as soon as possible. If you become eligible for additional or different insurance such as Medicare, you must inform me.
- This office will submit claims in a timely manner and will provide an update to you if the insurance company or MCO denies the claim.

D. Please give us this information as it appears on your insurance policies or cards.

Your Name:_____ Date of Birth:_____

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Name of Insurance Company:_____ Health Plan:_____

Policy #: _____ Group #: _____

E. If you are covered under someone else's insurance plan, please provide this information.

Policy holder's name:_____ Date of Birth:_____

Relationship to Patient:_____

Policy Holder's Address:_____

Name of Insurance Company:_____ Health Plan:_____

Policy #: _____ Group #: _____

F. Release of Information and Assignment of Benefits:
I, the client (or the policy holder), by my signature below authorize the release by this office of any information obtained during evaluations and treatment that is necessary to support and process any insurance claims, determine medical necessity, support any clinical or financial audits, or requests for additional sessions. I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the clinician or organization above. Medicare regulations may apply.

I understand that I am responsible for all charges, regardless of insurance coverage or other payments. I understand that I will be responsible to pay the session fee if I fail to cancel my appointment at least one business day in advance.

A photocopy of this assignment is to be considered as good as the original.

_____ _____

Client's (or policy holder's) Signature Printed Name

My signature indicates my agreement to and accuracy of all of the statements above.

Please bring your (or the policy holder's) health insurance card(s) with you to your first session.