

# BREAKTHRU

COUNSELING AND CONSULTING, P.C.

## Adult Payment Form

### PLEASE PRINT

Client Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number(s): Home: \_\_\_\_\_ Office: \_\_\_\_\_ Cell: \_\_\_\_\_

OK to leave a voicemail at work? Yes No Home? Yes No Cell? Yes No OK to Text Cell? Yes No

Email: \_\_\_\_\_ Ok to communicate by email? \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer: \_\_\_\_\_ Relation to Insured: \_\_\_\_\_

### FORM OF PAYMENT

Self-pay Yes No Medicaid Yes No

Medicare Yes No In Network Insurance Yes No

Out of Network Insurance Yes No Other \_\_\_\_\_

### INSURANCE, MEDICAID AND/OR MEDICARE INFORMATION

Insured's Name: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Ins. Effective Date: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy (or Group) No: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Benefits Phone #: \_\_\_\_\_ Precert. Phone #: \_\_\_\_\_

Name of person responsible for payment: \_\_\_\_\_

Address (if different from address above): \_\_\_\_\_

Do you have other insurance? \_\_\_\_\_ If so, which is primary? \_\_\_\_\_

**\*Please bring to your appointment a current Insurance, Medicare and/or Medicaid card.\***

Marital Status: Single Engaged Married Divorced Separated Widowed

Name of Spouse: \_\_\_\_\_ Age: \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Spouse's Work Phone #: \_\_\_\_\_

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I heard about BreakThru Counseling and Consulting, P.C. from: \_\_\_\_\_

**OTHER FORMS OF PAYMENT (EAP, CHURCH, ETC.)**

If a 3rd party other than insurance is going to be involved in paying the client’s charges, please complete the following: Name of 3rd Party Payer: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Additional Information: \_\_\_\_\_

**FEES**

The charge for the 1<sup>st</sup> session is \$175.00 (One hundred and seventy-five dollars) and sessions thereafter will be charged at a rate of \$ 150.00 (One hundred fifty dollars).

**Assignment of Benefits**

BreakThru Counseling & Consulting, P.C. (“BCC”)’s policy is for payment to be made when services are rendered. If this is a problem or if prior arrangements have been made, please contact Dr. Warner to discuss.

In consideration of services provided to me by”BCC”, I hereby assign to BreakThru Counseling and Consulting, P.C. all insurance benefits otherwise payable to me resulting from the care rendered by BreakThru Counseling and Consulting, P.C. and/or Dr. Quincy Warner and to make payment covered by this assignment directly to “BCC”.

I understand and agree that BreakThru Counseling and Consulting, P.C. may elect to accept or not accept such assignment. I further understand and agree that this assignment shall not be construed as relieving me from responsibility for any payment due and owing or which may become due and owing to BreakThru Counseling and Consulting, P.C. for services rendered to the client or from the obligation of remitting to BreakThru Counseling and Consulting, P.C. any insurance proceeds which I, as the client, may inadvertently be paid by any insurance company for claims arising out of treatment at “BCC”.

Signature of Client \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

**Permission to Release Information**

I give my permission for BreakThru Counseling & Consulting, P.C. and/or Dr. Quincy L. Warner to release any information about me to my insurance company, any other 3<sup>rd</sup> party payer and/or “BCC”’s billing and collections firms and, if needed, to any courts and/or regulatory agency (ex. Georgia Office of Insurance and Safety Fire Commission) necessary to process any claims and/or regulatory review that result from services rendered to me by “BCC” and Dr. Quincy L. Warner. This release can be revoked at any time by informing “BCC”/Dr. Warner in writing, except to the extent that action has been taken in reliance upon it. Otherwise, it stays in effect until payment in full is received by BreakThru Counseling & Consulting, P.C.

Client Signature: \_\_\_\_\_

Date \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_