

BreakThru

Counseling and Consulting, P.C.

CHILD/ADOLESCENT PAYMENT FORM

Parents and/ or Legal Guardian of the child who is to be the client should fill out this form.

Child's Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____ Age: _____

Custodial Parent or Guardian: _____

Relationship to Child: _____

Place of Employment of Parent/Legal Guardian: _____:

Telephone Number: Home: _____ Work: _____ Cell: _____

OK to leave a voicemail at Home? _____ Work? _____ Cell? _____ OK to Text Cell? _____

Email: _____ Ok to communicate by email? _____

Guardian's Marital Status: Single Engaged Married Remarried Separated Divorced Widowed

Other Adults Living with Child client: _____

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 DOB: _____

Insured's Social Security Number: _____

Insured's Employer: _____ Policy Effective Date: _____

Insurance Company: _____ Policy or Group Number: _____

Insurance Company Address: _____

Benefits Phone #: _____ Precertification Phone #: _____

Name of Person Responsible for Payment: _____

Address (if different from address above): _____

Insured's Home Phone # _____ Business #: _____ Cell #: _____

OK to leave a voicemail at Home? _____ Work? _____ Cell? _____

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

FEES The charge for the 1st session is \$175.00 and the charge for following sessions is \$ 150.00.

Please bring the client's current insurance card, Medicaid and/or Medicare documents to the 1st appointment.

Assignment of Insurance Benefits

BreakThru's policy is for payment to be made when services are rendered.

In consideration of services provided by BreakThru and Dr. Quincy L. Warner, I hereby assign to BreakThru Counseling and Consulting, P.C. all insurance or other third party payer benefits otherwise payable to me and/or the minor client listed below resulting from the care rendered by BreakThru Counseling and Consulting, P.C. and Dr. Warner, and to make payment covered by this assignment directly to BreakThru.

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 or other third party payer proceeds which I, or the client, may inadvertently be paid by any insurance company or other third party payer for claims arising out of treatment at BreakThru.

Child Client Name (Print)

Client Date of Birth

Signature of Parent or Legal Guardian

Date

Witness

Date

Permission to Release Information

I give permission for BreakThru Counseling & Consulting P.C. and Dr. Quincy L. Warner to release any information about the child named below, and/or me the undersigned guardian of the client named below, to the insurance company, any third party payer and/or to BreakThru's billing and collection firms, necessary to determine medical necessity of treatment, to secure authorization, respond to quality assurance requests, conduct regulatory reviews and/or to process any claims and receive payment that result from services rendered to the client by BreakThru and Dr. Quincy L. Warner. I also give permission for BreakThru and Dr. Quincy L. Warner to release any information about the client and me, the undersigned, necessary to receive payment for services rendered to small claims court and/or the Georgia Office of Insurance and Safety Fire Commission. This release can be revoked at any time by informing BreakThru/Dr. Warner in writing, except to the extent that action has been taken in reliance upon it. Otherwise, it stays in effect until all claims are processed, medical necessity & quality assurance issues are resolved and payment in full is received.

Child Client's Name (Print)

Legal Guardian's / Parent's Signature

Date

Witness

Date