

BREAKTHRU

COUNSELING AND CONSULTING, P.C.

Adult Client 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? Yes No

Date of Birth: _____ Age: _____

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 driver's license and 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 #: _____

(Continued on Back)

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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 1st session is \$200.00 (Two hundred dollars). The following 45 minute sessions charge is \$175.00 per session (One hundred seventy – five dollars). Payment is due at time of service. Payment is by credit, debit, HSA, FSA only for TeleMental Health sessions utilizing the HIPAA compliant Ivy Pay service. In person sessions can also be paid by check or cash. Please also be aware the return check fee is \$50.00. Note different fees apply for records release and participation in client legal matters. See “Psychologist- Client Services Agreement”.

I voluntarily choose and ask that my typed name on the signature line(s) of this document legally represent my electronic signature.

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 _____

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 3rd 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 _____