BreakThru

Counseling and Consulting, P.C.

CHILD/ADOLESCENT CLIENT 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: _____ County:_____ Zip: _____

Date of Birth: _____ Age: _____

Custodial Parent or Guardian: _____

If Guardian, what is your relationship to Child: _____

Employer of Parent/Legal Guardian: _____

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

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

Email: _____ Ok to communicate by email? ☐ Yes ☐ No

FORM OF PAYMENT

Self-pay ☐ Yes ☐ No Medicaid ☐ Yes ☐ No

Medicare ☐ Yes ☐ No Medicaid 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 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? ☐ Yes ☐ No Work? ☐ Yes ☐ No Cell? ☐ Yes ☐ No

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

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"

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

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

Assignment of Insurance Benefits

In consideration of services provided by Breakthru Counseling & Consulting, P.C. (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/Adolescent Client Name (Print) Client Date of Birth

_____

Name of Parent or Legal Guardian

_____ _____

Signature of Parent or Legal Guardian Date

Permission to Release Information

II give permission for Breakthru Counseling & Consulting, P.C. (BreakThru) and Dr. Quincy L. Warner to release to release any information about the child named below, and/or me the undersigned parent/guardian of the client named below, to the insurance company, any third party payer and/or to BreakThru's billing and collection services, 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/Adolescent Client Name (Print) Client Date of Birth

_____

Name of Parent or Legal Guardian

_____ _____

Signature of Parent or Legal Guardian Date