INSURANCE AND PAYMENT INFORMATION

Primary Insurance:____________________________________ Policy number:___________________
Name of insured:____
Address:____

Secondary insurance:__________________________________ Policy number:___________________
Name of insured:____
Address:____
Additional insurance information:____

Patient's condition related to:
Employment? Y___ N___ auto accident? Y___ N___ other accident? Y___ N___

Payment Agreement

The time we reserve for your appointments is reserved specifically for you. Therefore, we must require 24-hour notice for canceled appointments or a charge will apply.

We occasionally use the services of a collection agency after reasonable efforts are made to collect balances on accounts.

Please sign one of the following:

I will pay in full by cash or check at each appointment.

Signature:______________________________________Date:_________

-OR-

I am providing complete insurance information and authorize Delta Psychology Center to bill my primary insurance company for me. I will be responsible for any deductible or co-payment amount at each appointment. I hereby authorize my insurance company to pay benefits directly to Delta Psychology Center for this treatment. **If applicable, I have notified my insurance company and received initial pre-certification for this treatment.** ***I authorize Delta Psychology Center to release any information necessary to my insurance company and its agents any medical information about me to determine payments for these services.***

Signature:______________________________________ Date:_______