

**BILLING AND INSURANCE INFORMATION**

Name of Client: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Party to be Billed (If Other Than Self): \_\_\_\_\_

Billing Address (If different Than Home Address): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PRIMARY INSURANCE**

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Patient's Relationship to Insured: Please circle one Self / Child / Spouse / Other

Insured Social Security #: \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured Employer: \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_

Insurance Plan Phone: \_\_\_\_\_

Insurance Company Claims Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SECONDARY INSURANCE (IF APPLICABLE)**

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Circle Patient's relationship to Insured: Self / Child / Spouse / Other

Insured Social Security #: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Insured Employer: \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_

Insurance Plan Phone: \_\_\_\_\_

Insurance CO. Claims Address: \_\_\_\_\_

\_\_\_\_\_

- I authorize the release of any information necessary to process my insurance claim for benefits (including diagnosis). I agree to accept final responsibility for all payments of any professional services rendered to me. I will give 24 hours notice for cancellation of a session or pay the full fee for a missed session.

• **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

- I authorize Marie Kifun-Jones to bill my third party payor company for services rendered and authorize the payor to assign payment directy to Marie Kifun-Jones.
- I have received a copy of the HIPAA NOTICE OF PRIVACY PRACTICES and the MEMBERS RIGHTS AND RESPONSIBILITIES STATEMENT and I agree to participate in services provided by Marie Kifun-Jones.
- I agree to communicate with M Jones electronically and understand the risks involved and authorize the transmission of my protected health information and absolve her from any loss/error arising from such communication.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_