Barnes & Klatt, P.C.

INSURANCE RELEASE & PATIENT FINANCIAL RESPONSIBILITY

Note: Our office does not file to Secondary Insurance
Exception: Medicare

PLEASE NOTE: VERIFICATION OF INSURANCE BENEFITS IS NOT A GUARANTEE OF PAYMENT

PATIENT INFORMATION

Patient Name: _____ Age: _____ Birthday: _____

Email address : _____(For Minors Provide Family/Adult/Guardian email)

INSURED INFORMATION/POLICY HOLDER

Name of Insured: _____ Birthday: _____

Relationship to Patient: _____ ID/Social Security Number: _____

Employer: _____ Work Phone: _____

INSURANCE POLICY INFORMATION

Name of Insurance Company: _____

Group # _____ Policy # _____

Insurance Phone: _____

Did you call your insurance company to verify coverage? YES _____NO_____

Effective Date of Coverage:_____

Is Barnes & Klatt In-Network :_____Out-of-Network:_____

Do you have a deductible:_____$ How much has approximately been met:_____$

What is your Copay Amount:_____$
OR
What is your percent of coinsurance per session:_____%

Is pre-certification required? YES _____ NO _____

Authorization Number: _____

Number of Sessions Authorized: _____

Effective Date: From: _____/_____/_____ To: _____/_____/_____

OVER PLEASE

Name of Individual Responsible for Billing/Payment

Print Name_____

Address_____

City, State, Zip_____

Home Phone_____Work_____

Cell Phone_____

***SIGNATURE*_____**

Notice of Privacy Practices and Professional Service Agreement

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

THIS PROFESSIONAL SERVICE AGREEMENT NOTICE DESCRIBES IMPORTANT INFORMATION ABOUT OUR PROFESSIONAL SERVICES AND BUSINESS POLICIES. PLEASE REVIEW THESE CAREFULLY.

I have received the attached notice of privacy practices and service agreement.

_____(Initials) Patient (age 12 and older)

_____(Initials) Parent /Legal Guardian/Legal Representative.

I/we (the undersigned) authorize the release of any information necessary to process my claims. I/we also authorize the payment of benefits directly to the above named supplier who accepts assignment. It is understood that I/we have the responsibility for payment of services. Assignment of benefits to the insurance company does not release me/us from responsibility for payment. If for some reason my/our insurance does not cover the amount as stated above, I/we will be responsible for the remaining balance. **Any outstanding insurance balance beyond 90 days will be billed to the undersigned and be due upon receipt.**

This release is valid through _____ unless dated as follows _____.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

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