PAY BENEFITS TO PROVIDER/PA COUNSELING

We ask that all patients show their insurance cards or managed care membership cards so that we may make copies of them.

PRIVATE INSURANCE

I hereby authorize direct payment of behavioral health benefits to PA Counseling for services rendered under their care. I understand that I am financially responsible for any balance not covered by my insurance.

Patient Name: X_____ Date: X_____

Parent Guardian:_____ Date: _____

Witness:_____ Date: _____

MEDICARE/MEDICAID:

I certify that the information given by me in applying for payment is correct. I authorize release of all my records upon request. I request that payment of authorized benefits be made on my behalf. A photocopy of these cards shall be as valid as the original.

I request the payment of authorized Medicare benefits be made to me or on my behalf to PA Counseling for any services furnished to me by the clinician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable to related services.

Patient Name: X_____ Date: X_____

Parent Guardian:_____ Date: _____

Witness:_____ Date: _____

PAYMENT AGREEMENT

It is the policy of PA Counseling that charges (Copay, Coinsurance) for services rendered by Gayle Hinebaugh, MSW, LCSW be paid for at the time of service unless other formal arrangements have been made.

Electronic insurance claims will be filed by PA Counseling for your convenience. It will be your responsibility, however, to provide PA Counseling with the necessary information and signed authorization for filing insurance. This information and authorization must be provided to our office at your first visit, accompanied with a copy of your health insurance card(s). We will provide you with the papers needed to file a hard copy claim.

Arrangement for monthly payments may be made with PA Counseling for any patient account balance in excess of $100. A minimum payment is required each month to keep an account active. You are responsible for making the monthly payment by the 5th working day of each month whether or not a statement has been sent to you. Any patient account which becomes delinquent (monthly payment not made within 30 days of the last payment), will begin to be processed by collections and the complete balance will become due immediately.

I agree to the above financial agreement for any services provided to me by PA Counseling

Responsible Party Signature: X_____ Date: X_____