**Insurance**

Information and Authorization to Bill Insurance Company

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Name:** | | | | | | | | | | | | | | **DOB:** | | | | | | | | **Gender:** | |
| Client Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_  Street address City State Zip code | | | | | | | | | | | | | | | | | | | | | | | |
| Cell Phone: | | | | | | | | Home Phone: | | | | | | | | | | | | Relationship to insured: | | | |
| **Policy Holder Name** (if different than client)**:** | | | | | | | | | | | | | | | | | | | | | | | **DOB:** |
| Policy Holder Address:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_  Street Address City State Zip Code | | | | | | | | | | | | | | | | | | | | | | | |
| Cell Phone: | | | | | | | | Home Phone: | | | | | | | | | | | | | Work Phone: | | |
| **Primary Insurance Company:** | | | | | | | | | | | | | | | | | | | | | | | |
| Subscriber ID/Policy #: |  |  |  |  | |  |  |  |  |  |  | |  | |  | | Behavioral Health Phone #: | | | | | | |
| Deductible: $ | | | | | Deductible met: $ | | | | | | | Co-pay: $ | | | | | | | Any Authorization needed after therapy session? | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| Group Number: |  |  |  |  | |  |  |  |  |  |  | |  | |  |  | | | | | | | |
| Address of primary insurance company for filing claims by mail:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_ \_\_\_\_\_  Street Address City State Zip | | | | | | | | | | | | | | | | | |  | | | | | |
| **Name of person responsible for payment if not client, or policy holder:** | | | | | | | | | | | | | | | | | | | | | | | |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Street Address City State Zip Code | | | | | | | | | | | | | | | | | | | | | | | |
| Phone: | | | | | | | | | | | | Email: | | | | | | | | | | | |
| **Any additional info to include :** | | | | | | | | | | |  | | | | | | | | | | | | |

**Please read and initial:**

\_\_\_\_ I hereby acknowledge that I give Kelly S Johnson, Psy.D., permission to bill my insurance company. I understand that I am responsible for payment should my insurance company declare that my treatment is not medically necessary, refuses to authorize treatment and/or is not covered under your policy. I also understand Dr. Johnson might need to send records for review of medical necessity and approve it. Penalty fees may apply to unpaid bills.

\_\_\_\_ If my insurance is other than BC/BS PPO, I agree to pay Dr. Kelly S Johnson, directly for testing. Generally, she will bill for the initial interview and feedback session of the results for those who do not have BC/BS, but payment for testing is due at time of testing. Upon request, Dr. Kelly S Johnson will write a receipt for you, the client, to submit to your insurance company for reimbursement.

\_\_\_\_ If I do not use my current insurance now but choose to use it in the future, I will not ask Kelly S Johnson, Psy.D to submit for sessions already received.

\_\_\_\_ Iunderstand that if I have any questions regarding the use of my insurance, I can contact Dr. Kelly S Johnson, at 630-355-3321

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| --- | --- |
| **Person responsible for payment if not client:** | |
| Phone: | Email: |
| Relationship to client: | |

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**Signature of Client /or Parent/Guardian Date**