**Insurance**

Information and Authorization to Bill Insurance Company

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| **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? |
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| 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**