

WORCESTER YOUTH & FAMILY COUNSELING SERVICES, INC.

Client Information - Insurance

(Please Print)

Patient's full name: _____ **SS#** _____

Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Sex:** _____ **Age:** _____ **DOB:** ____ / ____ / ____

Patient Employer: _____ **Work #:** _____

Student Patients: High School _____ College _____

Family Physician: _____ **Referred By:** _____

Person to Contact in Emergency: _____ **Phone:** _____

Insured/Responsible Party Information

Please complete this section regardless of insurance coverage.

Name of Insured/Responsible Party: _____ **Relationship:** _____ **DOB:** _____

Occupation: _____ **Home Address:** _____ **Phone:** _____

Employer & Address: _____ **Phone:** _____

Insured's SS#: _____ **Driver's License#:** _____ **State:** _____

Spouse's Full Name: _____ **SS#:** _____

Spouse's Employer: _____ **Phone:** _____

Insured's Primary Ins. Co: _____ **ID#:** _____ **Group#:** _____

Secondary Ins.Co? ___ No ___ Yes; **Company:** _____ **Policy#:** _____

Job Related Injury-Workmen's Comp. Co: ___ No ___ Yes; **Company:** _____

Please Continue to Next Page

Date: _____

Therapist: _____

DSS (check one) Yes _____ No _____

Office Billing and Insurance Policy

1. I authorize use of this form on all of my insurance submissions.
2. I authorize the release of information to my insurance company(s).
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to my service provider.
5. I have fully disclosed all of my insurance information; including any secondary or tertiary insurance policies. I understand that I am responsible for any charges that accrue if all of my insurance information is not disclosed.
6. I understand that I am responsible for notifying Worcester Youth and Family Counseling Services for any and all insurance changes. Including but not limited to; policy changes, receiving of new cards, additional policies, etc.
7. I hereby permit a copy of this to be used in place of an original.

Name: _____

Signature: _____ Date _____

It is your responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by your insurance the day and time service is provided.

There will be a \$25.00 service charge for returned checks.

In the event your account goes to collections, there will be a 20% collection fee added to your balance.

There is a 24 hour cancellation policy which requires you to cancel your appointment 24 hours in advance between the hours of 8am to 4pm Monday through Friday to avoid being charged the fee and possible forfeiture of any specific appointment time slot.

Signature: _____ Date: _____