Authorization to Bill Insurance and Credit Card Information

As a courtesy, The Hartwell Clinic, PLLC will bill your insurance company, HMO, responsible party, EAP, or third party payer for you if you wish. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. Most insurance plans require a diagnosis as part of filing a claim. This diagnosis will be discussed with the client prior to providing a statement. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time You also understand and accept that you are fully responsible for all non-covered fees including but not limited to copays, denied coverage of previous sessions, denied coverage of future sessions, and untimely cancellation/no show fees.

Please provide the information below for the use of billing purposes:

Client's Name: ______________________________ Client's Birthday: ___________________________

Policy Holder:_______________________________ Policy Holder's Birthday:_____________________

Policy Holder's Home Address: ____

City: ___________________ State:______ Zip Code:___________

Policy Holder's Employer:____

Policy Holder's Employer Address:____

City: __________________ State:______ Zip Code:___________

Insurance Company:____

Insurance Provider Phone Number:___________________________________

Member ID#: _____________________________________ Group#: __________________________

Payment in the form of check or cash or credit card is due at the beginning of each appointment. You agree that you are responsible for all charges for services provided by The Hartwell Clinic, PLLC to the client, although other persons or insurance companies/EAP's may make payments on the client's account.

The fee schedule is defined below. The Hartwell Clinic, PLLC reserves the right to change any of the fees below.

- Individuals/ Family or Couples
  - Initial Session – $85 for 60 minute session
  - Regular Sessions – $85 for 45 minute session
  - Overages – Clients may be charged for extended sessions

- Groups
  - Initial visit – cost and duration of sessions vary by group topic
  - Regular visits – cost and duration of sessions vary by group topic
  - Overages – Clients may be charged for extended sessions

Contact Information of Financially Responsible Party:

Name:____ Date of Birth: __________________________

Home Address: ____

City: __________________ State:______ Zip Code: ________________________

Phone Number: ________________________________ Relationship to Client: ____________________

The Hartwell Clinic, PLLC only accepts Visa, MasterCard, and Discover credit cards. This credit card number is required to be on file by The Hartwell Clinic, PLLC in order to hold appointments. A missed session is a session where the client cancels the session with less than 24 hours notice or does not arrive to the session. **If a client cancels with less than 24 hours notice or fails to arrive at the appointment, the credit card on file will be charged $55.00 for the missed appointment.**

Name on Credit Card: ____

Credit Card Type (circle one): Visa MasterCard Discover

Credit Card Number: ____ Expiration Date: ____________

CVC Code:_________________________________ Billing Zip Code: ___________

After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. If after 90 days the fees are still unpaid within the above terms, the client's account may be turned over to a collection agency. The client or responsible part will be held responsible for any collections fee charged to my office to collect the debt owed.

Quoted Benefits:

For my convenience, The Hartwell Clinic, PLLC has been quoted the benefits listed below by your insurance company/EAP. It is understood that quoted benefits do not guarantee payment. It is also understood that all non-covered fees or charges will be the responsibility of the client or responsible financial party listed above. Any changes to my insurance/ EAP/ or third party payer must be conveyed to The Hartwell Clinic, PLLC within a timely manner.

Mental Health Insurance Company:____
Person spoke to, date, and time of call:____________________________________
Amount Remaining on Deductible:____
Effective Date of Policy___________________
Max Payable Per Session__________________
Percent Coverage________________________
Max Payable per calendar year______________
# of Sessions Authorized___________________

Dr.'s Referral needed_________
Copay ____________________
CPT Codes 90791___ 90837__ 90847__
Precertification ID #_____________________

I understand and agree that I am responsible for all charges incurred on behalf of ___________________ _________________________, the client of The Hartwell Clinic, PLLC. I consent for my credit card information to be kept on file. I will provide in writing if I no longer want charges to be billed to this credit card and/or if the billing party has changed. I have read and understand all the above information.

____ ____________________

Financially Responsible Party's Signature Date