FOR OFFICE USE ONLY:
DX:_____Therapsit:_____

MIDWEST CENTER FOR HUMAN SERVICES, L.L.P.

INSURANCE COVERAGE INFORMATION

(PLEASE COMPLETE ALL SECTIONS)

PLEASE PRINT AND COMPLETE ALL ENTRIES					
Patient Name (Last, First MI)		Date of Birth ___/___/___	Age	Marital Status	Today's Date ___/___/___
Address (Street – City – State – Zip)		Home Phone (_____) _____-_____		Work Phone (_____) _____-_____	
Employer Name				Cellular Phone (_____) _____-_____	
Employer Address (Street – City – State – Zip)		Occupation		Social Security No.:	
Spouse's Name (Last, First, MI)	DOB ___/___/___	Social Security No.		Spouse's Work Phone (_____) _____-_____	
Emergency Contact who does not live with you	Relationship			Phone (_____) _____-_____	
Who is financially responsible for this bill?					
How will the bill be paid today?					

- If both spouses in a household carry health insurance, the primary policy is the one in **your name**. Your spouse's insurance, if it covers you, is secondary.
- If the client is a minor child who is covered as a dependant on both parents' insurance, the parent whose birth date comes earlier in the calendar year is **primary** and the other parent's insurance is secondary.

INSURANCE INFORMATION

Primary Insurance Name	Address (Street – City – State – Zip)		Phone (_____) _____-_____
Name of Insured	Relationship	I.D. No.	Group No.
Secondary Insurance Name	Address (Street – City – State – Zip)		Phone (_____) _____-_____
Name of Insured	Relationship	I.D. No.	Group No.

ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE THE ABOVE INSURANCE COMPANY/COMPANIES TO MAKE PAYMENTS DIRECTLY TO THE PROVIDER FOR THE BENEFITS HEREIN AND OTHERWISE PAYABLE TO ME. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

_____

(signature) (date) (OVER)

MIDWEST CENTER FOR HUMAN SERVICES, L.L.P.

SERVICE AGREEMENT

Client Name: _____

I (we) agree to the following conditions:

1. Unless other arrangements are made, to pay all or a portion of my service fee at the time of service (at each session)*. I understand that if I have insurance coverage, reimbursement will be made directly to me or refunded through the clinic. In the event that I can not pay all of my service fee at each session I will agree to pay _____ per session. I understand that Midwest will carry the balance of my account which will be settled based upon insurance reimbursement. I understand that I am responsible for the payment of all fees regardless of insurance coverage.

2. To pay for missed appointments, including group sessions, unless I give 24 hour advance notice, or I am prevented from giving notice by an emergency. I understand that missed appointments are not billable to my insurance company. This charge will be my personal responsibility.

3. To pay for periodic psychological/psychiatric case consultation as a requirement of State of Wisconsin clinic certification at the rate of $25.00 per consultation. I understand that my insurance company may cover this fee, but that I am responsible for payment if they do not provide coverage.

4. I understand the cost for the initial session is _____. The cost of a "psychotherapy hour" is _____. I understand that the psychotherapy hour consists of a 45-50 minute face-to-face visit and also includes 10 minutes of administrative time which is used for telephone calls, charting, record review, etc. Additional charges may result for case consultations and report preparation. On occasion the therapy hour may not be exactly 45-50 minutes. I understand that in such cases the fee is prorated. For any other services provided the fee will be discussed prior to receiving the service. Other services may include:
   a. Group Therapy $_____
   b. Psychological Evaluation $_____
   c. _____

5. I understand that I will be billed per therapist. Thus, a couple or family being seen by two therapists will be billed for two therapists. The only exception is for group therapy sessions.

6. I understand that a reduction in fees may be available at the discretion of my therapist.

7. I understand that any balance due as shown on the invoice is payable within 30 days. I further understand that if I do not make full payment of the invoice within the 30 day period, I will pay a late payment charge of 1% per month of the remaining balance. I understand that I can avoid the late payment charge my making timely payment.

8. I understand that I will be charged a fee of $10.00 for any checks returned by the bank for insufficient funds.

9. I understand that if my account becomes delinquent, Midwest may turn it over to a collection agency and/or report uncollected past due charges to the Internal Revenue Service.

Notes/Comments:

_____

_____

_____

I have read the above statements and agree to the terms as outlined.

_____ _____ _____

Signature Date Midwest Staff

- *MasterCard / Visa available upon request. A 3% courtesy fee will be added to your charge.*

Revised: 12/2015
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