Client Financial Information and Fee Agreement Form

Client Last Name: _____
Client First Name: _____
Date of Birth: _____
Social Security #: _____

PERSON FINANCIALLY RESPONSIBLE FOR THE CLIENT

Relationship to Client:
( ) Self ( ) Spouse ( ) Dependent ( )Parent

Last Name:_____ First Name:_____

Responsible Party DOB: _____

Street Address: _____ City:_____ State: _____
Zip Code: _____
Home Phone: _____ Work Phone: _____
Place of Employment: _____

PRIMARY INSURANCE POLICY HOLDER

Policy Holder's Last Name: _____ First Name:_____
M.I._____
Policy Holder's SSN: _____
Insurance Company Name: _____
Policy Holder's DOB: _____
Policy Holder's Employer: _____
Insurance Co. Phone #: _____
Policy #: _____ Group #: _____
Insurance Type: (Please Check) ( ) Individual ( ) Family ( ) Other

I have reviewed the above document. I understand that co-pays and deductibles are an estimate base on the information Helene Trujillo, LCSW received from my insurance company and are subject to change. I have completed the requested information completely and to the best of my knowledge. I have received a copy of the form. I agree to assume responsibility and pay the Network the assigned Fee(s)/Insurance fee(s).

I authorize Helene Trujillo, LCSW to release my information for all claims and payment purposes, as may be required by my insurance company or any third party payer, and release Helene Trujillo, LCSW from any liability related to such release of information.
I assign all benefits and rights to payment for services to Helene Trujillo, LCSW, an authorize payment to be made directly to Helene Trujillo, LCSW by any third party payer that provides benefits or payment for such services.

Client Signature_____ Date: _____

Therapist Signature: _____ Date: _____