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BILLING INFORMATION FORM

Today's Date: _____ Referred by: _____

Federal record keeping guidelines and insurance company regulations require that only **one** person be identified as the person receiving services, even if you are seeking care as a couple or as a family. **Please select and enter the name of the person you wish to have listed as the client of record:**

Client Name: _____ Date of Birth: _____ SS#: _____

If the client named above is a child:

School: _____ Grade: _____ Teacher: _____

BILLING INFORMATION

Name of person responsible for paying for services: _____

Date of Birth: _____ SS#: _____ Driver's License #: _____

E-mail: _____ Occupation: _____

Home Address: _____ Employer: _____

_____ Work Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Circle one: Single Paired Married Separated Divorced Remarried Widowed

If you have a significant other, continue here and provide information about the significant other.

Name: _____ Cell Phone: _____

E-mail: _____ Occupation: _____

Home Address: _____ Employer: _____

_____ Work Address: _____

Home Phone: _____ Work Phone: _____

Is the client an adult with children? Yes No If Yes, fill out below. If No, please go to the next section.

Name(s) of children, if any Birth Date School, if any

- 1.
2.
3.
4.
5.

Is the client a child? Yes No If Yes, fill out below. If No, please go to the next section.

Name(s) of brothers or sisters, if any Birth Date School, if any

- 1.
2.
3.
4.
5.

FEE PAYMENT INFORMATION

Unless otherwise arranged, payment is due at the time services are rendered. Please select how you would like to pay:

cash/check/money order OR VISA MC Discover:

Card number: Expiration date: Security Code:

Billing address associated with card:

Address City State Zip

Authorized signature:

Unless otherwise arranged: A 10% service charge will be applied to overdue fees. Clients' agreed-upon, full session fee will be applied when clients cancel appointments without 24 hours advance notice.

HEALTH INSURANCE INFORMATION

Please check where applicable:

I am an Aetna or Blue Shield member and I would like to use my insurance to pay for sessions. (Dr. Gum is both an Aetna and Blue Shield Provider and will submit these insurance claims for you.)

I am an Aetna or Blue Shield member but I do not want to use my insurance. (Dr. Gum will prepare and Insurance Waiver Form for you to fill out and sign.)

I am not an Aetna or Blue Shield member but I would like to obtain partial reimbursement from my insurance carrier. (Dr. Gum will prepare an insurance claim form for you at the end of each month.)

In any of the above cases, please bring your insurance card with you to your first session and fill out the following:

Name of Insurance Carrier: Name of Insured:

ID #: Group #: Other insurance? Yes No

Name of Insured, Other Policy: Name of Other Carrier:

Group and/or ID of Other Policy:

FOR STAFF USE ONLY

ICD 9 CM Dx: Fee: HICF? Yes No