CONNECT PSYCHOLOGICAL SERVICES, LLC

CLIENT INFORMATION

Name: _____ Preferred Phone: _____

Address: _____ City/State/Zip: _____

Email Address: _____ Date of Birth: _____

Occupation: _____ Referred by: _____

Emergency Contact: _____Phone: _____

Agreement to contact ER Designated Person: _____All telehealth clients require a designated ER person or local resource I can contact in an emergency.

INSURANCE INFORMATION (BCBS PPO in network provider only)

Primary: _____ Secondary: _____or [ ] No secondary

Phone: _____ Type: HMO PPO EPO POS other _____

Group Name/Number: _____

Policy or ID Number: _____

Responsible Party: _____ Birthdate: _____

I understand I am fully responsible to pay for my services. I authorize the release of any medical information necessary to process claims for me and/or my dependents on my behalf, and I authorize payment of benefits to this practice for claims submitted on my behalf. I understand if I am using out-of-network benefits, I can request a superbill to seek reimbursement from my insurance company. I understand if I do so, they may request further treatment information and I authorize the release of my medical information. I understand that I am financially responsible for noncovered benefits, and all deductibles and co- payments not covered by this authorization. I understand insurance payment is not guaranteed and some services are not routinely covered. I am aware that this provider is only a BCBS PPO provider, and she does not accept Medicare or Medicaid.

Signature: _____Date: _____

I plan to opt out of using insurance. I understand I am financially responsible for all fees outlined in the service agreement. I understand I will be provided an estimate of my costs called a Good Faith Estimate.
Signature: _____Date: _____