Insurance

Information and Authorization to Bill Insurance Company

Client Name:	**DOB:**	**Gender:**
Client Address: _____, _____, _____ _____ Street address City State Zip code		
Cell Phone:	Home Phone:	Relationship to insured:
Policy Holder Name (if different than client)**:**		**DOB:**
Policy Holder Address: _____ _____, _____ _____ Street Address City State Zip Code		
Cell Phone:	Home Phone:	Work Phone:
Primary Insurance Company:		
Subscriber ID/Policy #:		Behavioral Health Phone #:
Deductible: $	Deductible met: $	Co-pay: $ / Any Authorization needed after therapy session?
Group Number:		
Address of primary insurance company for filing claims by mail: _____, _____, _____ _____ Street Address City State Zip		
Name of person responsible for payment if not client, or policy holder:		
Address: _____ _____, _____ _____ Street Address City State Zip Code		
Phone:	Email:	
Any additional info to include :		

Please read and initial:

____ I hereby acknowledge that I give Kelly S Johnson, Psy.D., permission to bill my insurance company. I understand that I am responsible for payment should my insurance company declare that my treatment is not medically necessary, refuses to authorize treatment and/or is not covered under your policy. I also understand Dr. Johnson might need to send records for review of medical necessity and approve it. Penalty fees may apply to unpaid bills.

____ If my insurance is other than BC/BS PPO, I agree to pay Dr. Kelly S Johnson, directly for testing. Generally, she will bill for the initial interview and feedback session of the results for those who do not have BC/BS, but payment for testing is due at time of testing. Upon request, Dr. Kelly S Johnson will write a receipt for you, the client, to submit to your insurance company for reimbursement.

____ If I do not use my current insurance now but choose to use it in the future, I will not ask Kelly S Johnson, Psy.D to submit for sessions already received.

____ I understand that if I have any questions regarding the use of my insurance, I can contact Dr. Kelly S Johnson, at 630-355-3321

Person responsible for payment if not client:	
Phone:	Email:
Relationship to client:	

_____ _____

Signature of Client /or Parent/Guardian **Date**