Hoffman Behavioral Health

Financial Agreement

Name:_____ Date of Birth:_____

In-Network Insurance Authorization:

Dr. Marney Hoffman, PhD, LPC, LMHC has my permission to bill my insurance company(s) and to provide necessary information for the purposes of obtaining authorization for services, benefit information, and payment. I agree that payments or copays for service are due at the time of the service and the responsibility for payment is mine. Denial of payment by an insurance carrier or other third party does not waive my responsibility to pay. I understand that no show or late cancelled sessions (less than 24 hours notice) will be charged to me at full fee and cannot be charged to my insurance company. I agree that a NSF fee of $35.00 will be assessed for any returned check. My signature below indicates that I fully understand and agree to these terms.

Signature: _____ Date:_____

Primary Insurance:

Primary Policy Holder's Name _____Date of Birth_____

Address_____City_____State_____

Zip_____ Phone_____ Client's relation to Policy Holder_____

Insured's employer_____

Primary insurance company_____

Identification #_____Group #_____

Deductible met? _____Yes _____No Deductible amount $_____

Effective Date of Coverage:_____

I authorize Dr. Marney Hoffman to release any information to my insurance company, which may be deemed necessary in order to process an insurance claim. I further authorize that my insurance benefits be paid directly to Dr. Marney Hoffman. I agree to notify Dr. Marney Hoffman immediately whenever there are changes in my health condition or health plan coverage in the future.

Signature_____ Date_____

Hoffman Behavioral Health

Financial Agreement

Name:_____ Date of Birth:_____

Out-of-Network Insurance Benefits or Out-of-Pocket Payment Agreement:

I, _____, am choosing to make out-of-pocket payments for the clinical services I receive with Marney Hoffman, PhD, LPC, LMHC. I am doing this for the following reason(s):

_____I do not presently have insurance that covers mental health benefits.
_____I have mental health benefits with _____(Insurance Company), however:

_____I have exhausted my current outpatient mental health benefits.
_____I am choosing not to use my insurance benefits at this time.
_____I wish to be treated by Dr. Marney Hoffman who is not a paneled member with my insurance network.
_____My concerns are not deemed medically necessary by my insurer and thus are not covered by my insurance benefit.

Fees for Service: $150 Initial Assessment, $125 Individual (45-minute session), $150 Individual (53-minute session), $150.00 Couple (53-minute), $225.00 Couples (90-minute).

Agreement to Begin Treatment:

This agreement pertains to services beginning _____(date) and will remain in effect until such time as a new written agreement is made, or a valid insurance authorization is obtained and I consent for Dr. Marney Hoffman to bill my insurance, or I leave treatment. I understand that that I am responsible for payment for any and all services rendered and that such payment is due at the time of the visit. Payments for services provided can be made via cash, check, or debit/credit cards. I understand that no show or late cancelled sessions (less than 24 hours notice) will be charged to me at full fee and will not be reimbursed to me by my insurance company. I agree that a NSF fee of $35.00 will be assessed for any returned check. My signature below indicates that I fully understand and agree to these terms.

Signature_____Date_____