FAMILY SOLUTIONS SERVICES, INC.
THERAPY INSURANCE INFORMATION/FINANCIAL POLICY
1217 Hwy 10 W., P.O. Box 258, Orange City, IA 51041 Ph: 712-707-9222 Fax: 712-707-9220
505 5th St., Suite #510, Sioux City, IA 51101 Ph: 712-258-4553 Fax: 712-258-4773

INSURANCE/VERIFICATION INFORMATION:

Patient Name:	**Insurance Company:**
Policy Holder:	**Policy Holder SS#:**
Policy Holder DOB:	**Insurance ID#:**
Employer:	**EAP Authorized: Y or N # of sessions:**

I HAVE PROVIDED FAMILY SOLUTIONS WITH A COPY OF MY INSURANCE CARD: Y OR N

WE WILL VERIFY YOUR INSURANCE INFORMATION AND ELIGIBILITY BY CALLING YOUR INSURANCE COMPANY, HOWEVER IT IS YOUR RESPONSIBLITY TO CONTACT YOUR INSURANCE COMPANY YOURSELF REGARDING YOUR BENEFITS AND YOUR RESPONSIBLITY IN THE AMOUNT THAT IS OWED BY YOU FOR EACH SESSION AT FAMILY SOLUTIONS SERVICES.

FINANCIAL POLICY

- I understand that I am responsible for any and all Co-Payments and/or Deductibles to my private insurance company.
- **I understand that all Co-Payments are due at the time of service prior to each session.** Co-Payments may be made payable by cash or check. Further, I acknowledge I will be charged $20.00 for non-sufficient funds (NSF), if payment is made by check.
- I understand that if I need to be billed for Co-Payments, I will be charged an additional $20.00 if payment is not sent within 30 days.
- I realize any benefits quoted to me by Family Solutions Services, Inc. staff is not a guarantee and that exact benefits may not be known by Family Solutions Services, Inc until my insurance company makes payment on my account.
- I will contact my insurance directly with any questions I have regarding my benefit level and/or co-pay amounts as they apply to my appointments at Family Solutions Services, Inc.
- I understand that Family Solutions Services, Inc. staff is not responsible for providing this information to me.
- I understand that if my account is turned over to a collection agency, any and ALL fees incurred for collection of the balance due on my account will be added to my balance owed.
- I understand that Family Solutions Services, Inc. is a service to me and will bill my insurance company, but ultimately I am responsible for payment for all incurred charges for treatment at Family Solutions Services, Inc.
- **I UNDERSTAND THAT THIS IS A SUMMARY OF MY MENTAL HEALTH BENEFITS OBTAINED FROM MY INSURANCE COMPANY. THIS IS NOT A GUARANTEE OF PAYMENT.**

CONFIDENTIAL COMMUNICATION

Alternative Address to be used for communication: _____

_____

Alternative Phone Number to be used for communication: _____

- **May we leave a message? Yes No**
- **Can the message list the name of Family Solutions Services? Yes No**
- **May we leave identifying information? Yes No**

DATE OF SIGNATURE:

Patient (Guardian if patient is a minor) or other Authorized Individual's Signature:
Subscriber to Insurance (if different from patient) or other Authorized Individual's Signature:

rev: 7/14