

Psychotherapy Billing Form - Karen Kruzan LISW-S

Client: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_

**If Spouse is the Insurance Holder:** Spouse's Name: \_\_\_\_\_ Spouse's D.O.B: \_\_\_\_\_

Spouse's Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_

Primary Insurance Company Name: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Policy Holder's S.S. #: \_\_\_\_\_ Client's Relationship to Policy Holder: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_ ID Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Deductible: \_\_\_\_\_ CoPay: \_\_\_\_\_ Authorization Number: \_\_\_\_\_

Credit card information for your co-pay

I \_\_\_\_\_, give approval to Dennison Associates, Inc. to store my credit card information in their system and to submit all billing for K<sup>2</sup> Organizing, LLC. Stored credit card information will be used to cover any co-payments, deductibles, or balances due within a 30-day period of the date of service. A 3.5% convenience fee will be added to all charges.

Credit Card Number: \_\_\_\_\_ 3-Digit Code: \_\_\_\_\_

Credit Card Type: Visa or Master Card only: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

I certify that the information provided is correct. In the case of using managed care insurance, which required a pre certification I agree that I am responsible for this pre certification of sessions. Dennison Associates will bill the client in the case that insurance pre certification is not obtained. I understand that payment is to be made at the time of the session, and that I am also authorizing Dennison Associates to release my treatment records, if required, to my primary care physician or insurance company. This release will terminate one year from my last appointment unless written notice of extension is given.

Signatures:

Client or responsible party: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_