SOUTHEAST FAMILY COUNSELING
6436 S. Quebec Street, Suite 100
Englewood, Colorado 80111
Robert L. Feder, LCSW 720-488-3168 Sharon S. Feder, MS 303-669-8932

PATIENT AGREEMENTS & AUTHORIZATIONS

REFERRAL INFORMATION

How did you find out about us?

_____
(doctor, therapist, insurance company, former patient, etc.)

Where would you like your monthly statement sent? (Please check) Patient:____ Responsible Party:____

PAYMENT AGREEMENT

(Please initial)

_____It is understood that the responsible party should obtain an authorization number prior to the initial therapy session depending on insurance policy, otherwise they are responsible for payment of services rendered.

_____For office and home based psychotherapy, and other professional services, payment in full is required at the time services are rendered unless prior arrangements are made. I/we agree to be responsible for all charges for professional services rendered on behalf of the identified patient, including any charges not reimbursed (co-pay, deductible, coinsurance) by my insurance carrier unless a special arrangement has been agreed upon in writing.

_____It is further understood that I/we will be responsible for missed appointments unless a 24 hour notice is given prior to scheduled appointment. If it is less than 24 hours and the spot cannot be filled then you are charged half the hourly rate. If no notice is given then you are charged the full hourly rate. Insurance does not cover cancelled and missed appointments.

The signature(s) below indicate that I/we understand Southeast Family Counseling financial policies and certifies that I/we are financially responsible for services provided. I/we will be responsible for any collection or attorney fees or court costs associated with use of outside agencies required for collection of my/our account.

INSURANCE AUTHORIZATION TO RELEASE INFORMATION

_____I/we authorize the release of any information from the patient information form, above information and any medical information necessary to, 1) provide for adequate professional coverage in the absence of the primary doctor/therapist, 2) to verify insurance coverage and 3) to file a claim for insurance benefits related to professional services rendered.

AUTHORIZATION OF ASSIGNMENT OF BENEFITS

_____I/we authorize direct payment of insurance benefits from (Insurance Co.) _____
_____to Southeast Family Counseling/Robert L. Feder, LCSW for professional services rendered.

Patient Signature:_____Date:_____
(if over 15)
Printed Name:_____

Responsible Party Signature:_____Date:_____

Printed Name:_____