Ellen Savage

ellen@ellensavage.com Amalia PC

Licensed Clinical Professional counselor #27 PO Box 395 Chinook MT 59523 406-262-4242

TODAY's DATE _____20___

Patient's Full Name _____, _____Spouse/parent_____

Street Address _____, City_____, State_____Zip_____

Mailing Address _____

Email address _____@_____.com

Phone numbers (home/cell/work/contact)_____

Patient's Employer, Address & Phone_____

Patient's Date of Birth ___/___/___ Social Security Number (required for billing) ____-___-_____

Who may we thank for referring you to this office? _____

Do you have Medical Insurance Coverage? _____Yes _____No

Are you the primary Insured with this Coverage? _____Yes _____No

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If Patient is not Primary Insured, what is the name of the person who is _____

---Relationship to Patient? _____

---Primary's Person's DOB _____/_____/_____

---Primary's SS# _____-_____-_____ Phone Contact _____

Co-payment, if known $_____._____

EAP Data if applicable _____

BILLING AND PAYMENT POLICY

1. In return for a fee as per your insurance company allows in your policy, you will receive outpatient therapy services. The fees paid vary for initial Interview and Intake, and the length of time of a session. **If you do not have insurance, the fee is $80-$120/session and due upon each visit. You will be responsible for all co-payments and funds allotted to your deductable or other Health Plan.**

2. Fees for services other than in-office visits, such as but not limited to, telephone consultation with yourself and others related to the matter, attorneys, social services, report-writing, emailing/e-searches, distance counseling, will be charged to you.

3. As a courtesy to our patients, we may bill some insurance carriers. Some companies no longer pay directly to this office. Your insurance coverage is an agreement/contract between you and your insurance company. If you have questions or difficulties receiving reimbursements, please contact your insurance company. You are ultimately responsible for payment of all services rendered. You may be provided with a form from this office to submit to your Carrier for reimbursement.

4. Insurance companies will provide limited information to this office regarding coverage; if you want to know how you are covered for these services please phone your Carrier and ask about coverage for "Outpatient Mental Health". Be aware if you use another term you may be told there is no coverage. This information is in your policy book and also will be given to those covered with correct identification.

5. If attempts to have you pay on your account prove to be ineffective the unpaid balances over 120 days will be turned to an outside collection agency. To prevent this from occurring I strongly recommend you phone for arrangements.

6. If the matter is pursued in court for non-payment, responsible party will be liable for any/all attorney fees and/or court costs.

7. **IN THE EVENT YOU WILL NOT BE ABLE TO KEEP YOUR APPOINTMENT, YOU MUST NOTIFY THE OFFICE 24 HOURS IN ADVANCE. IF WE DO NOT RECEIVE ADVANCE NOTICE YOU WILL BE RESPONSIBLE FOR PAYING FOR THE MISSED SESSION.**

_____

_____

NAME DATE

_____

_____

NAME DATE

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_____I/We authorize use of the form on all my insurance submissions.

_____I/We authorize release of information regarding billing to all my insurance companies.

_____I/We understand that I am responsible for my bill.

_____I/We authorize my doctor/provider and billing company (Back Office Solutions, LLC)to act as my agent in helping me obtain payment from my insurance companies.

_____I/We authorize payment direct to doctor/provider when billing is not sent by yourself.

_____I/We permit a copy of this authorization to be used in place of the original.

_____I/We have reviewed a copy of HIPAA standards for this office.

Do we have your permission to call your phone and leave a message?

***Home phone Yes____ No____**

Cell phone Yes____ No ____

Work phone Yes____ No ____

Regarding appointments? Yes _____ No_____

Regarding account information? Yes_____ No_____

Name(s) _____/_____

Signature(s)_____/_____

Date _____/_____/20_____

PLEASE NOTE! IF YOU ARE BEING SEEN IN THIS OFFICE FOR AN INITIAL VISIT AS A COUPLE, BOTH OF YOU MUST SIGN THESE FORMS. THANK YOU.