

# Ellen Savage

[ellen@ellensavage.com](mailto: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

\*\*\*\*\*

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 deductible 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 MAY BE RESPONSIBLE FOR PAYING FOR THE MISSED SESSION.**

\_\_\_\_\_  
NAME DATE

\_\_\_\_\_  
NAME DATE

# Ellen Savage

Amalia PC

Licensed Clinical Professional counselor #27

PO Box 395 Chinook MT 59523

406-262-4242

\_\_\_\_\_ 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.**