Inspiring Talkers Therapy and Learning Center

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www.inspiringtalkers.com

Insurance Information and Financial Policy

Today's Date: _____

Patient Name: _____ DOB: _____
Primary Physician: _____ Phone: _____

Please Check if you will be private Paying or using commercial insurance:
☐ Private Pay ☐ Insurance (complete below)

Insurance #1 Name: _____
Policy Holder's Name: _____ Policy Holder's Date of Birth: _____
Policy Number: _____ Group: _____

Insurance #2 Name: _____
Policy Holder's Name: _____ Policy Holder's Date of Birth: _____
Policy Number: _____ Group: _____

****Please provide Inspiring Talkers with a copy of applicable insurance cards****

Inspiring Talkers appreciates that you have chosen us to provide your therapeutic needs. The services you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full for our fees. As a courtesy, we will attempt to verify your coverage and bill your insurance on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect co-payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer.

I have read the above policy regarding my financial responsibility to Inspiring Talkers, for providing services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Inspiring Talkers, the full and entire amount of the bill incurred by me or the above named patient.

Responsible Party Signature: _____ Date: _____

Claim Payments Made Directly to Policy Holder

I fully understand that any payments made directly to the policy holder must be rendered to Inspiring Talkers within 3 weeks.
Responsible Party Signature: _____ Date: _____

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected to be paid at the time of service.

Responsible Party Signature: _____ Date: _____

Self-Pay Policy

I do not have health insurance nor wish to not have my insurance billed for the services rendered here at Inspiring Talkers. I will be responsible for all costs and agree to pay Inspiring Talkers the full and entire amount of treatment given to me or the above named patient.

Responsible Party Signature: _____ Date: _____