Infinite Hope
COUNSELING

Financial Information

CLIENT INFORMATION

Client's Name: (Last) _____ (First) _____ (MI) ____

Client's Address:_____ City:_____ State:_____ Zip:_____

Client's DOB: _____/_____/_____ Gender: Female☐ Male☐ SS#: _____

Cell #: (_____) _____-_____ Home #: (_____) _____-_____ Work #: (_____) _____-_____

► *If you do not have or you do not wish to use insurance coverage, please skip to the responsible party for payment section.*

SUBSCRIBER'S INFORMATION

If the client is the subscriber, please disregard this section. N/A ☐

Subscriber's Name: (Last) _____ (First) _____ (MI) ____

Subscriber's Address:_____ City:_____ State:_____ Zip:_____

Subscriber's DOB: _____/_____/_____ Gender: Female ☐ Male ☐ SS#: _____

Cell #: (_____) _____-_____ Home #: (_____) _____-_____ Work #: (_____) _____-_____

Relationship to Client: Self ☐ Spouse ☐ Parent/Legal Guardian ☐ Other ☐ *specify:* _____

PRIMARY INSURANCE

Infinite Hope Counseling LLC must have a copy of this insurance card, or your insurance carrier may not be billed properly. N/A ☐

Primary Insurance Name: _____ Phone #: (_____) _____-_____

Address:_____ City:_____ State:_____ Zip:_____

Subscriber ID Number: _____ Group Number: _____ Group Name: _____

Insured Through: Self ☐ Employer ☐ Employers Name: _____ Other ☐ *specify:*_____

SECONDARY INSURANCE

Infinite Hope Counseling LLC must have a copy of this insurance card, or your insurance carrier may not be billed properly. N/A ☐

Secondary Insurance Name: _____ Phone #: (_____) _____-_____

Address:_____ City:_____ State:_____ Zip:_____

Subscriber ID Number: _____ Group Number: _____ Group Name: _____

Insured Through: Self ☐ Employer ☐ Employers Name: _____ Other ☐ *specify:*_____

RESPONSIBLE PARTY FOR PAYMENT

if different from client or subscriber N/A ☐

Responsible Party's Name (Last) _____ (First) _____ (MI) ____

Address:_____ City:_____ State:_____ Zip:_____

Subscriber's DOB: _____/_____/_____ Gender: Female ☐ Male☐ SS#: _____

Cell #: (_____) _____-_____ Home #: (_____) _____-_____ Work #: (_____) _____-_____

Relationship to Client: Spouse ☐ Parent/Legal Guardian ☐ Other ☐ *specify:*_____

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COUNSELING

Financial Agreement

FINANCIAL AGREEMENT

To make sure we are operating on the same agreement regarding sessions, Infinite Hope Counseling LLC has defined the following guidelines. Once you have agreed upon an appointment time, you are responsible for that time. If you foresee that you cannot keep the appointment time, you will need to give Infinite Hope Counseling LLC at least a 24-hour cancellation notice or you will be charged for the time. Medical emergencies are acceptable for short notice (please call the office and leave a message if you have a medical emergency cancellation).

Infinite Hope Counseling LLC's fees are fair and competitive. Here are the standard rates:

- Initial Evaluation: $165.00
- Individual Psychotherapy, 45-50 minutes: $110.00
- Individual Psychotherapy, 55-65 minutes $165.00
- Couples or Family Psychotherapy, 45-50 minutes: $125.00
- Group Psychotherapy, 45-50 minutes: $55.00

Full payment is due at the time of service unless Infinite Hope Counseling LLC is a participating member to your insurance plan. Insurance coverage is a contract between you and your insurance company. It is your responsibility to know and provide the limitations on your plan's coverage. In some cases, Infinite Hope Counseling LLC may be a party to this contract. Please ask if Infinite Hope Counseling LLC is a participating member to your insurance plan; otherwise, deductibles and reduced benefits may apply. Your copayment is due at the beginning of each session. Fees will vary with the type of services provided. Cash, credit card, or check is accepted. Please make checks payable to Infinite Hope Counseling LLC. The service charge for returned items is $55.

Infinite Hope Counseling LLC will handle your claim according to the agreement with your insurance company. You must notify Infinite Hope Counseling LLC of any changes in your coverage within 15 days of the change. Infinite Hope Counseling LLC will not become involved in disputes between you and your insurance company (i.e., deductibles, co-payments, coverage changes, secondary insurance) other than to supply factual information as necessary. You are responsible for all non-contractual fees unpaid by your insurance company.

Infinite Hope Counseling LLC is not a participating Medicare provider. Infinite Hope Counseling LLC will provide you with information required by Medicare for an accurate billing in the event you wish to request reimbursement for payment of services.

For the processing of third party claims, Infinite Hope Counseling LLC utilizes TherapyNotes, a HIPAA-compliant, web-based mental health practice management program that includes integrated billing.

COLLECTION

Timely payment is expected. In the event that your balance goes unpaid, Infinite Hope Counseling LLC will turn your account over to a collection agency. Any fees incurred by Infinite Hope Counseling LLC to collect on your bill will be your added responsibility. I understand that should I default on payment of my account and collection agency services are required, all costs of collections up to 40% of the balance, including attorney/court costs, will be added to the balance of my account. Please direct all billing inquiries to (406) 980-0672.

AUTHORIZATION & INSURANCE COMPANY RELEASE OF INFORMATION

I/We hereby authorize Infinite Hope Counseling LLC to disclose to my/our insurance company(s), listed above, the following information: patient name, date(s) of service, service(s) provided, and diagnosis, to be used for the purpose of insurance evaluation and reimbursement, unless otherwise specified in a separate authorization to disclose additional clinical information.

This information will be disclosed to the above insurance company from records whose confidentiality is protected by Montana and/or federal law. These regulations prohibit the above insurance company from making any further disclosure of this information without prior written consent. I/We understand that I/we have no obligation whatsoever to disclose any information from my/our record. I/We understand that I/we may revoke this consent at any time by notifying Infinite Hope Counseling LLC or the above-noted person, organization, or agency, in writing and/or by specifying an event or condition upon which my/our consent will expire without revocation. I/We have read or had this form read and explained to me and I/we understand its contents.

I/We have completed the above to the best of my/our ability and fully understand the importance of this relationship. I/We have reviewed the terms in the document, and agree to abide by the terms as outlined for services provided by Infinite Hope Counseling LLC. With my/our signature I/we give my/our consent to provide the necessary information for any and all billing of the services rendered.

_____ _____

Client Signature Date

_____ _____

Parent/Legal Guardian Signature *mandatory if client is a minor* Date