Davis Behavioral Health

Client ID:_____

Financial Update

CLIENT DEMOGRAPHIC INFORMATION
Client Name [last, first, middle]:_____
Parent/Guardian Name [last, first]:_____
Alias and/or Maiden Name:_____
Address [include city, state & zip]:_____
Home Phone:_____ Cell Phone:_____ Other [message]:_____
Email:_____ How do you prefer to be contacted:_____

INSURANCE INFORMATION
Insurance Company Name:
Insurance Phone Number:
Policy Holder Name:
Policy Holder Address:
Policy Number:

CO-PAYMENT: It is my responsibility to pay my co-pay at the time of each session. I also understand I will be responsible for the co-payment on charges that my private insurance, including Medicare, elects to not participate in. Should my private insurance pay me directly, I understand I will be billed the full cost of service, regardless of my discounted co-pay, until I turn over the money received and a copy of my explanation of benefits. Should my account be turned over to a Collection Agency, I will be charged an 18% service fee.

INSURANCE: I understand my insurance company will be billed the full cost to provide services. Regardless of what my insurance company might pay, I am expected to pay my co-payment each time I receive services. It is my responsibility to contact my Insurance Company for any prior authorizations that might be necessary in order for my services to be covered. I authorize Davis Behavioral Health to release personal health information for the billing of third party sources for benefits which I am eligible to receive. I agree that payments for services I receive at DBH will be sent to DBH. I also understand and agree that anything not paid for by my health insurance or other third parties (anybody else who might pay) will have to be paid by me. This agreement will last for the time I am treated or until my balance for treatment is paid in full, whichever is later.

CANCELLATIONS & NO-SHOWS: I understand that if I'm unable to attend my appointment I must call within 24 hours and cancel my appointment.

_____ Initial

Copay: I understand that I'm responsible to pay my insurance copay (if applicable) at the time I check in for my appointment.

_____ Initial

Collections: If for any reason your account has not been paid in full at discharge, an 18% collection fee will be added and the account will be turned over to collections.

_____ Client Signature

_____ Print Name

_____ Date

01/14/2020

Received By:_____