

CLIENT BILLING INFORMATION FORM

Patient Info:

Patient Name: _____ Date of Birth: _____
Patient's I.D. Number: _____ SSN #: _____
Relationship to Insured: _____
Address: _____ Marital Status: _____
Home Phone #: _____ OK to call? Y N Cell Phone #: _____
Work Phone #: _____ OK to call? Y N
E-Mail: _____
Employer: _____ Occupation: _____

Insured Info (If different from patient info):

Name: _____ Date of Birth: _____
Insured's I.D. Number: _____ SSN #: _____
Address: _____
Phone #: _____ Other Phone #: _____
E-Mail: _____
Employer: _____ Occupation: _____

Insurance Info:

Insurance Company: _____ Insurance Type (HMO, PPO): _____

Authorization # (if applicable): _____

- Please bring your insurance card with you to the first appointment. Please call your insurance company to obtain any required authorizations.
- We will bill your insurance company according to the information provided by you. If the fees are not paid, we will then turn to you for payment and you may work with your insurance company directly for reimbursement.
- I Authorize Jessica St. Clair MFT to bill my insurance for services rendered and to accept reimbursement from my insurance company. I agree to pay any co-pays and amounts charged to satisfy my deductible.

Signature of Patient/Parent/Guardian: _____ **Date:** _____

Credit Card Payment Information:

For credit card payments we use PayPal, an easy and convenient online payment service. If you prefer to pay with credit, we will send invoices to your email address. Please note: all credit card payments have a 4% convenience fee added to the total amount.

We appreciate payment for services within 30 days. If we do not receive payment with cash or check for any outstanding balance more than 30 days old, we will automatically bill you using PayPal.