Counseling Connections ADK

88 Woodruff Street
Saranac Lake, New York, 12983
(518)523-6516

INDIVIDUAL PAYMENT PLAN AGREEMENT

In order to assist us to serve you better, we need the following information. Please feel free to discuss with your therapist any financial concerns you may have.

Date:____

PATIENT INFORMATION:
Social Security Number:____________________________ Sex: __________ Date of Birth:_____________________________
Last Name:____ First Name:_______________________________ MI:__________
Address:____
City:__________________________________ County:___________________________ State:_______ Zip Code:__________
Home Phone:____________________________ Work Phone:___________________________ Other:_____________________
Employer Name:_____________________________________ Address:____
Spouse's Name:________________________ Spouse's DOB:_________________ Spouse's Employer__________________
Dependent under 25?__________ If yes, give birth order (e.g., 2 of 6)________ F/T Student?____________________________
Parents' names and birth dates:____
Emergency contact:____________________________ Relationship:______________________ Phone number:______________
Referred by:____

INSURANCE INFORMATION
Primary Insurance Company Name:____
Policy Holder's Name:_______________________________________ Policy Holder's SS#______________________________
Patient Relationship to Insured:____
Policy Number:____ Group Number:___________________________________
Effective Date:____ Deductible:_____________________________________
COBRA Benefit?:____ Primary or Secondary:__________________________
Secondary or Spouse's Insurance Company Name:____
Insured's Name:____
Relationship to Insured:____
Policy Number:____ Group Number:___________________________________
Effective Date:____ Deductible:_____________________________________
Primary Care Physician:____ Office Phone Number:______________________
Address of PCP:____
If you object to information going to your Primary Care Physician, mark here____________

_______ I wish to pay 100% of charges
_______ I wish to assign my insurance benefits to pay provider directly for services. I will personally pay any deductible or co-payment liability portion of charges directly to the provider of services.
_______ I would like to discuss this further with the provider of services. Please state the alternative plan you would like to establish for your payment of services:____
____

OFFICE POLICY: While we do not charge interest on outstanding balances, any and all attorney, court or collection costs required to cover delinquent accounts will be added to the outstanding, unpaid balance. By their signatures, this plan is understood and agreed upon by both parties. 24 hour notice is required for cancellation of visits or a charge will be made. There is a $25.00 charge for returned checks.

____________________________________	____________________________________
Person responsible for patient coverage	Provider of Services
Date____________________________	Date____________________________