Yellowstone Counseling Center

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Licensed Clinical Professional Counselors
208 N. Broadway, Ste. 423 Billings, MT 59101
Phone 406-896-8427 fax 406-245-5980

Fee/ Insurance Agreement

Client Name: ____ **M** ______**F** ______

Date of Birth: _______________ **Social Security Number:** __________________________

Address: ____
City: ____________________ **State:** ________ **Zip:** ____________________

Primary Phone for confidential voicemail: ______________ **Alternate Phone:** ____________

By providing an email, I give Yellowstone Counseling Center permission to send me <u>Email Reminders</u> for my future appointments. Email: ____

Emergency Name and Number: ____

If client is a minor - Parent/Guardian Name: ___________________________________
Address (if different than above): ____________________ **City:** ________ **State:** ____
Zip: ________ **Phone:** ________________

<u>Who is financially responsible for this account?</u> **Name:** ___________________________
Address: ______________**City:** ___________ **State:** _____ **Zip:** _______ **Phone:** _________
Employer: __________________ **Address:** ____________________________

If you have EAP, INSURANCE, or MEDICAID please fill out the following:
We are unable to accept Medicare at this time.

<u>Employee Assistance Program (EAP)</u>: ____________________ **Number of Sessions**________

Address: ____

Phone Number: _________________________ **Authorization #**____________________

Authorization Period: From _______________ **To** _________________________

<u>Name of Primary Insurance Company</u>: ____

Insurance Address: ____

Insurance Phone Number: ____

Insured's I.D. Number: ____

Group Number: ____
***This information is required in order to process insurance claims accurately.**
Policy Holder's Name: __________________**Relationship to Insured Party:**______________
Address: ____________________________ **City:** _________ **State:** _____ **Zip:** _______
Phone: ______________**Insured's DOB:** ___________ **Social Security Number:** ____________

Name of Secondary Insurance: ____

Insurance Address: ____

Insurance Phone Number: ____

Insured's I.D Number: ____

Group Number: ____

***This information is required in order to process insurance claims accurately.**
Policy Holders' Name: ______________________**Relationship to Insured Party:**______________________
Address: ______________________ **City:** __________ **State:** ______ **Zip:** ________
Phone: ______________**Insured's DOB:** ____________ **Social Security Number:** ________________

Fees: Initial appointment $180.00; 50-minute sessions $150.00; Group Therapy $60.00 for each session. Please remember that insurance coverage is a contract between you and your insurance company. If your insurance company does not pay for your services in our office, you will be responsible for the balance. In addition to weekly appointments, it is our practice to charge on a prorated basis for other professional services you may require such as report writing, telephone conversations which last longer than 10 minutes, attendance at meetings or consultations with other professionals which you have authorized, preparation of records or treatment summaries, or the time required to perform any other services which may be required.

If you are not covered by insurance or are self-pay, you are required to pay in full at time of service. Payments paid in full will receive a 5% discount.

Appointments must be canceled 24 hours in advance to guarantee there will be no charge. Failure to cancel or show for appointments will result in a regular charge for the sessions. When sessions are late cancelled or missed it prevents others in need from being served. Repeated missed appointments or late cancellations may result in referral to another therapist. A service fee of $35.00 will be added for all checks returned for insufficient funds or closed accounts.

I authorize the release of any medical or other information necessary to process this claim. I agree to the conditions above and authorize my insurance company to pay directly to Yellowstone Counseling Center.

PATIENT OR AUTHORIZED PERSON RESPONSIBLE FOR PAYMENT SIGNATURE:

Signed: ______________________________**Date:** ______________________

Print: ______________________________ **Print:** ______________________
Client Name **Guardian Name**

Internal Use Only: Initial Date Seen: ________**F-code:** ______________ **Therapist:** ______________