Kathia Lopez Murdock, LCPC

FINANCIAL AND OFFICE POLICY - CLIENT INFORMATION FORM

Patient First Name:_______________________Middle Initial:____Last Name: __________________________

Street Address:___________________________City: ____________ State: ____ Zip Code (+4):____________

Home Phone:_______________ Cell: ________Office:____

Birthdate: ___________SS#:_____________________Age:____Sex: ____Marital Status: _______

Home E-Mail Address:____

What is the best number to call to leave a confidential message?_________________

How were you referred to Kathia Lopez Murdock, LCPC: _______________________________________?

Name and Address of Billing Party (if different than above)

Name:

Street Address:

City: State: Zip:

If you use email to contact me, I cannot guarantee patient confidentiality, nor can we ensure receipt and reading of the message by the intended recipient.

I, as the patient, hereby give permission for Kathia Lopez Murdock, LCPC to provide counseling for myself.

Name ______________________________________

(Signature of Patient)

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If patient is a Minor, I, as parent or guardian, hereby give permission for Kathia Lopez Murdock, LCPC to provide counseling/testing for my child/children listed above.

Parent or Guardian Signature____ Date________________

Parent or Guardian Signature____Date________________

Kathia Lopez Murdock, LCPC

Insurance Information:

1. Name of Insurance Company? __________________ ID#: ________________

   Group#: _________________________

2. Address of insurance company: ____________________________________

3. Telephone# of Insurance Company: __________________________________

4. Name of primary insured: ___________________________ DOB: _________ SS#: ________

5. What is the amount of your co-pay due at time of each visit?

Our Financial and Office Policy:

1. All counseling sessions are 45 to 60 minutes in length unless otherwise specified.

2. My standard fee is $150 per session, unless otherwise specified. Fees are payable at the time of each appointment. You are responsible for any fees not covered by your insurance company. We will discuss fee payment, fee adjustment, and the use of insurance benefits at the first session, if you choose to use insurance to pay for your therapy sessions,

3. I am currently paneled with BCBS IL and Blue Choice. Your providing of insurance information and signature as indicated on this form directs and authorizes Kathia Lopez Murdock to release Personal Health Information (PHI) to your insurance companies for the purposes of requesting financial reimbursement for my therapy fees. It is important to stress that if you intend to submit, or have me submit, for reimbursement through your insurance, then your privacy will be compromised, as I am required to provide a diagnosis and, in some instances, treatment records, plans, or updates in order for your insurer to continue to reimburse you for my services. In case you want to submit out of network claims, I will be happy to provide you with appropriate documentation to submit to your insurer for possible reimbursement. Please be aware that your insurer is under no obligation to reimburse for my services, and reserves the right to deny any claim for services.

4. Payment is expected at the time of each visit if we are not filing insurance. If we file insurance, co-pays and co-insurance are billed at time of service. If there is an amount not covered by insurance (such as a deductible) it is added to your account balance after insurance has paid. You may request a monthly billing history that you can submit to your Insurance Company for reimbursement if you are going to submit a claim for yourself.

5. *I charge one standard session fee for appointments that are missed or cancelled with less than 24 hour notice. These charges are not covered by insurance and will be the patient's responsibility.*

6. If you request your records be sent to another physician, therapist or school, a case summary report is prepared, the expenses for which are your responsibility and will be charged according to time spent to prepare such reports

7. IT IS YOUR RESPONSIBILITY TO CALL YOUR INSURANCE COMPANY PRIOR TO

YOUR FIRST VISIT IN ORDER TO CHECK ON YOUR OUT-PATIENT MENTAL HEALTH BENEFITS AND ASK IF PRE-AUTHORIZATION IS REQUIRED . IT IS YOUR RESPONSIBILITY TO BE AWARE OF CHANGES TO YOUR INSURANCE PLAN DURING THE COURSE OF YOUR THERAPY THAT MAY AFFECT YOUR COVERAGE AMOUNTS, AND TO PAY ACCORDINGLY THE PATIENT PAYMENTS SPECIFIED.

It is important that you understand and agree to my financial and office policy. Please call if you have any questions, 773 570 0497.

I have read and understand the above financial and office policies, to which I agree.

Name ____ Date: ______________
(Signature of Patient or Parent/Guardian if Minor)

I authorize Kathia Lopez Murdock to release Personal Health Information (PHI) directly to insurance companies that I indicate in this form, as required, so that reimbursement may be requested for my therapy session expenses.

Name ____ Date: ______________
(Signature of Patient or Parent/Guardian if Minor)