

Karen Truesdell Bierman, Ph.D.
Clinical Psychologist
160 Creekside Park, Suite 202
Spring Branch, Texas 78070
(830) 438-9211
(830) 438-7585 Fax

Financial Information Form

Please refer to the Psychotherapist-Client Services Agreement for information regarding my professional fees and payment policies. Complete the following form so appropriate insurance arrangements for payment of professional fees can be made. Feel free to discuss any financial concerns with me, or any member of my office staff.

A. Client: _____ Client DOB _____ Client Soc. Sec.# _____

Billing address: _____ Home phone: _____

- ❖ Our office maintains a **24-hr cancellation policy** for all appointments. Any missed appointments, without prior cancellation, are subject to a cancellation fee of \$25 per visit. Please be courteous and notify us ahead of time if you will need to reschedule your appointment. We appreciate your cooperation.
- ❖ If you are not using health insurance, please check here ____ and proceed to the back of this page.

If you have health insurance, it may pay for a part of the cost of your treatment here. To find out if this is so, my staff and I need the information requested below. **Complete this section only if you will be using health insurance benefits to cover professional service fees.**

B. Insurance Co. _____ Policy # _____

Policy Holder: _____ Group/Plan #: _____

Policy Holder's DOB: _____ Policy Holder's Soc. Sec. # _____

Policy Holder's home address: _____

Policy Holder's employer _____ work phone: _____

We are happy to file your claims with your primary insurance company. However, it is not our policy to bill secondary insurance policies, although we can provide you with the paperwork needed to do this on your own. If you plan on filing with secondary insurance, please check here _____. You can request a copy of your billing statement after each appointment.

C. I give this office permission to release any information obtained during examinations or treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.

D. I understand that I am responsible for all charges, regardless of insurance coverage. Payment of required co pays, coinsurance fees, or deductibles will be collected (cash or check only) at the time of service. We regret that we are unable to accept credit cards at this time.

E. Assignment of benefits

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the therapist above. Medicare regulations may apply. A photocopy of this assessment is to be considered as good as the original.

Client's (or parent/guardian's) signature,
Indicating agreement to all of the statements above

Date

Printed name

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Complete this page only if you are not using health insurance.

There are many excellent reasons why people choose not to file for health insurance benefits for psychological services. If you have any questions about this topic, please discuss them with Dr. Squyres.

Client name: _____ Social Security #: _____

Please check one of the following.

- | | |
|--------------------------|--|
| <input type="checkbox"/> | I do not have health insurance and I will be paying professional fees directly to Dr. Bierman. |
| <input type="checkbox"/> | I do have health insurance but I am choosing not to file any claims for benefits related to these services. |

Please note:

If you have insurance and choose not to use it at this time, please understand that we cannot submit claims for prior services at a later date, should you change your mind about using your insurance.

I understand and agree with the statements listed above.

Client's (or parent/guardian's) signature,
Indicating agreement to all of the statements above

Date

Printed name