Patti Bear, Licensed Professional Counselor

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pattibearlpc.com

541-357-7468

Fee Agreement

Client Name: _____ Date of Birth: _____

Insurance Information

Insurance Company: _____

ID# _____ Group # _____

Name of Insured: _____

DOB of Insured: _____ Client Relationship to Insured: Self Partner Child

_____I do not have insurance/do not want my mental health treatment billed to my insurance. I agree to pay for each counseling/therapy session at the time of service. (Please initial here and sign below if applicable.)

Assignment of Benefits

RELEASE OF INFORMATION: I authorize **Patti Bear, LPC** to disclose and release to my insurance carrier(s), including TriWest/Tricare (VA beneficiaries), Medicare, Medicaid, Medigap/Supplemental benefits providers, and private insurers, as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form as the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize my provider to act as my agent in helping obtain payment from my insurance companies.

ASSIGNMENT OF BENEFITS: I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to my provider for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation.

MEDICARE AUTHORIZATION: If a Medicare beneficiary, I understand my signature requests payment to be made and authorize the release of medical information necessary to pay claims. If 'other health insurance' is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes the release of information to insurance companies or its authorized agents. In Medicare-assigned cases, the physician or supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and I agree I am responsible for deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

AGREEMENT OF RESPONSIBILITY: I understand that copayments, coinsurance, and deductibles are due at the time of service. I understand I am financially responsible for charges not covered by my insurance company

_____ _____

Client/Responsible Party signature Date