Changing Times:

Therapy for Individuals, Couples, and Families

FINANCIAL INFORMATION

_____I am self-pay and have agreed with my therapist the rate of $ 125.00 per session unless the provider agrees to a lessor rate.

_____I have another arrangement made such as my University/College or Church is paying for my sessions.

_____I am using my health insurance. Please complete below.

Insured's Name _____Insured's Date of birth _____

Insured's Phone_____

Relationship to Client _____ Insured's Address_____

City _____ State _____ Zip _____

Insurance Company _____Policy #_ _____
Group# _____ Insured's SS#_____

PERMISSION TO BILL INSURANCE

I give permission to Forever Changed to bill my insurance and obtain any information that is necessary to process my insurance claims. I understand that Forever Changed must provide a clinical diagnosis to my insurance company and that this information is part of my record with Forever Changed and the insurance company. I further acknowledge that I am financially responsible for all charges not covered by my insurance.

Client/Responsible Party Signature _____
Date _____ (If client is over the age of 12, client signs here.)

Parent/Guardian _____
Date _____

Signature #2 (for couples) _____
Date _____