

INSURANCE AGREEMENT FORM

MARGARET V. MOORE, LISW

In order to provide you with detailed information regarding our services, we request that you review the following agreement and sign in the spaces provided below. If your insurance company requires an original claim form, please provide it to this office. Thank you for your cooperation. Your therapist is an individual practitioner and is completely responsible for the management of her own practice. She is not a member of an agency or a group practice. In the event that your Therapist is unable to continue to meet with you her representative will refer you to an appropriate Licensed Mental Health Practitioner.

Initial ____ All clients are expected to give 24 hour notice for any appointment cancellations. If this is not done, you will be charged a full fee. Your insurance will not be billed for these charges, therefore, you are responsible for the fee.

Initial ____ The client, or named responsible party, is accountable for the entire balance due for Services. Your therapist has contracted with Mr. Meticulous Billing Services (MMBS) to do all insurance and client billing. They will be filing for any applicable insurance benefits. MMBS must have complete insurance information including name, address and phone number and social security number to file your claim. MMBS would be happy to answer any questions you may have regarding your account (505-270-6935). Office hours are 9-3 M-Thurs and 9-6 on Friday. Please schedule all appointments with your therapist.

Initial ____ A. If pre-authorization for services is necessary, the client must initiate this with the Insurance company.
B. If you have a deductible, it is payable to this office, up front and per visit.
C. In the event of an overpayment, a refund will be sent to the authorized party.

Primary Insurance Company _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNITURES

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits wither to myself or to the party who accepts assignment.

Signed _____ Date _____

PAYMENT ARRANGEMENTS (to be arranged with your therapist at your first visit)

Fee\$ _____ plus tax per therapeutic hour

____ Client to pay in full each session and given a superbill to file their own insurance OR

____ MMBS will file the insurance claim(s). Deductible and/or copay due at time of session

DX _____