LIFE MANAGEMENT ASSOCIATES, LLC

LMA

CLIENT FINANCIAL INFORMATION, FINANCIAL AGREEMENT & INSURANCE COMPANY RELEASE

NEW CLIENT FINANCIAL INFORMATION: *In order to fill out the form completely, you will need to have a copy of your insurance card(s), the subscriber's date of birth, and the subscriber's social security number. The client's social security number and date of birth are also required regardless of age, for insurance company identification purposes. For your protection, we are requiring photo ID for the client, parent or guardian at the time of the initial appointment.*

Client Name (First) _____ (MI) _____ (Last) _____

Address: _____ City: _____ State: _____ Zip: _____

SS#: _____-_____-_____ DOB: _____/_____/_____ Gender M___ F___

Home #: (_____) _____-_____ Work #: (_____) _____-_____ Cell #: (_____) _____-_____

If you do not have or you do not wish to use insurance coverage, please skip to the Responsible Party for Payment section.

PRIMARY INSURANCE
We must have a copy of this insurance card, or we may not be able to bill the insurance carrier properly.

Name of Insurance: _____ Phone #: (_____) _____-_____

Address: _____ City: _____ State: _____ Zip: _____

Subscriber's Name (First) _____ (MI) _____ (Last) _____

SS#: _____-_____-_____ DOB: _____/_____/_____

Relationship to Client: Self ☐ Spouse ☐ Parent/Legal Guardian ☐ Other ☐ *specify:* _____

Insured Through: Self ☐ Employer ☐ Employers Name: _____

ID Number: _____ Group Number: _____

SECONDARY INSURANCE
We must have a copy of this insurance card, or we may not be able to bill the insurance carrier properly.

Name of Insurance: _____ Phone #: (_____) _____-_____

Address: _____ City: _____ State: _____ Zip: _____

Subscriber's Name (First) _____ (MI) _____ (Last) _____

SS#: _____-_____-_____ DOB: _____/_____/_____

Relationship to Client: Self ☐ Spouse ☐ Parent/Legal Guardian ☐ Other ☐ *specify:* _____

Insured Through: Self ☐ Employer ☐ Employers Name: _____

ID Number: _____ Group Number: _____

RESPONSIBLE PARTY FOR PAYMENT
If different from client

Client Name (First) _____ (MI) _____ (Last) _____

Address: _____ City: _____ State: _____ Zip: _____

SS#: _____-_____-_____ DOB: _____/_____/_____

Home #: (_____) _____-_____ Work #: (_____) _____-_____ Cell #: (_____) _____-_____

Relationship to Client: Spouse ☐ Parent/Legal Guardian ☐ Other ☐ *specify:* _____

2510 Continental Drive • Butte, MT 59701 • Phone: 406-782-4778 • Fax: 406-782-1318

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FINANCIAL AGREEMENT

To make sure we are operating on the same agreement regarding sessions, we have defined the following guidelines. Once you have agreed upon an appointment time, you are responsible for that time. **If you foresee that you cannot keep the appointment time, you will need to give us at least a 24-hour cancellation notice or you will be charged for the time.** Medical emergencies are acceptable for short notice (please call our office and leave a message if you have a medical emergency cancellation).

Our fees are fair and competitive. Here are our standard rates:

- Initial Evaluation: $225.00
- Individual Psychotherapy, 38-52 minutes: $150.00
- Individual Psychotherapy, 53+ minutes: $225.00
- Couples or Family Psychotherapy, 38-52 minutes: $150.00
- Couples or Family Psychotherapy, 53+ minutes: $225.00
- Group Psychotherapy, 38-52 minutes: $75.00

Full payment is due at the time of service, unless we are a participating member with your insurance plan. Insurance coverage is a contract between you and your insurance company. It is your responsibility to know and understand the limitations on your plan's coverage. In some cases, we may be a party to this contract. Please ask if we are a participating member with your insurance plan. If we are not, reduced benefits, in addition to deductibles and copays may apply. Your copayment is due at the beginning of each session. Fees will vary with the type of services provided. Cash, credit card, or check is accepted. Please make checks payable to Life Management Associates, LLC. Our service charge for returned items is $55. We will handle your claim according to our agreement with your insurance company. You must notify us of any changes in your coverage within 15 days of the change. We will not become involved in disputes between you and your insurance company (i.e., deductibles, co-payments, coverage changes, secondary insurance) other than to supply factual information as necessary. You are responsible for all non-contractual fees unpaid by your insurance company.

IMPORTANT INSURANCE QUESTIONS

- Does your policy cover individual counseling? No ☐ Yes ☐
- Does your policy cover family counseling? No ☐ Yes ☐
- Does your policy cover couples counseling? No ☐ Yes ☐
- Do you have to get prior authorization for counseling? No ☐ Yes ☐
  - *If so, how do I go about getting authorization?*
- Are there a maximum number of sessions covered per year? No ☐ Yes ☐
  - *If yes, what is the limit?* _____
- Does your counselor have to be a provider with your company in order for your sessions to be covered? No ☐ Yes ☐
- Do you have to get a referral from your primary care physician for counseling? No ☐ Yes ☐
- How much of your deductible have you met at this time? $_____ of $_____
- What is your benefit year? Calendar Year ☐ Fiscal Year ☐
- What is your financial responsibility (i.e., co-pay, co-insurance) after your deductible has been met? $_____/per session.
- Does your company use an employee assistance program that you have to use before starting counseling sessions through your plan's coverage? No ☐ Yes ☐

COLLECTION

Timely payment is expected. In the event that your balance goes unpaid, for 120 days, we will turn your account over to a collection agency. Any fees incurred by us to collect on your bill will be your added responsibility. Please direct all billing inquiries to our billing staff at (406) 782-4778.

AUTHORIZATION & INSURANCE COMPANY RELEASE OF INFORMATION

I/We hereby authorize Life Management Associates, LLC to disclose to my/our insurance company(s), listed above, only the following information: patient name, date(s) of service, service(s) provided, and diagnosis, to be used for the purpose of insurance evaluation and reimbursement, unless otherwise specified in a separate authorization to disclose additional clinical information.

This information will be disclosed to the above insurance company from records whose confidentiality is protected by Montana and/or federal law. These regulations prohibit the above insurance company from making any further disclosure of this information without prior written consent. I/We understand that I/we have no obligation whatsoever to disclose any information from my/our record. I/We understand that I/we may revoke this consent at any time by notifying Life Management Associates, LLC or the above-noted person, organization, or agency, in writing and/or by specifying an event or condition upon which my/our consent will expire without revocation. I/We have read or had this form read and explained to me and I/we understand its contents.

I/We have completed the above to the best of my/our ability and fully understand the importance of this relationship. I/We have reviewed the terms in the document, and agree to abide by the terms as outlined for services provided by Life Management Associates, LLC. With my/our signature I/we give my/our consent to Life Management Associates, LLC, to provide the necessary information for any and all billing of the services rendered.

_____ _____/_____/_____

Responsible Party for Payment Signature Date

_____ _____/_____/_____

Parent/Legal Guardian Signature *mandatory if client is a minor* Date

_____ _____/_____/_____

Representative of Life Management Associates, LLC Date

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