FINANCIAL RESPONSIBILITY

Primary Insurance Name: _____ Behavioral Health Phone Number: _____

Policy Number(Include letters): _____ Group Number: _____

Insurance Claims Address (Back of Card): _____

PolicyHolder Name: □Self Full Name/Relationship: _____

Policy Holder DOB: _____/_____/_____ Policy Holder SSN: _____-_____-_____

SecondaryInsuranceName:_____ BehavioralHealthPhoneNumber:_____

Policy Number: _____ Group Number: _____

INSURANCE ASSIGNMENT AND SELF PAY AGREEMENT

I certify that I have insurance coverage with the primary insurance company and the second insurance payer, if applicable, listed above. I assign directly to HoverH, PLLC (Liberty Hill Counseling Center/ Eternal Grace Counseling/ Providers et al) all insurance payments, if any otherwise payable to me for services rendered.I understand I am financially responsible for any deductible, co-insurance, copayment, non-covered charges, and any balances not covered under a signature for all insurance submissions. I understand that it is my responsibility to pay for any services rendered at the time of visit.

FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT

Payment for services rendered is the responsibility of the patient, parent, or guardian. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage on your behalf. However, you are ultimately responsible for the payment of your bill, regardless of insurance coverage. Once insurance claims have processed, any remaining balance(s) will be billed to the patient.If the insurance company fails to process claims within 45 days from the date of service, the balance due may be collected from the patient. If insurance issues arise, it is the responsibilityofthepatienttocontacttheinsurancecompany,groupplan,administrator,oremployer representativefor resolution. A patient's insurance policy is a contract between the patient and the insurance carrier. HoverH, PLLC and its associates are not parties to that contract and cannot act as a mediator with the carrier or employer. The patient will become responsible for complete payment to the provider if coverage has terminated due to lack of premium payment.

As required by insurance mandates, it is the responsibility of the patient to obtain any necessary authorization for medical treatments. If a referral is required for treatment, it is the responsibility of the patient to obtain the referral and present it at the time of treatment.If the patient is treated without the proper referral or authorization as required by the insurance carrier, the patient assumes responsibility for payment of all fees at the time of service.

PRE-AUTHORIZED USE OF CREDIT CARD

I authorize HoverH, PLLC (Liberty Hill Counseling Center/ Eternal Grace Counseling) and it's associates to keep my signature on file and to charge my credit card during my course of treatment at HoverH, PLLC (Liberty Hill Counseling Center). Charges include any payments that are patient responsibility including but not limited to: deductibles, copay, co-insurance and any non-covered or denied insurance payments.

Patient's Name:_____ Patient's DOB:_____

Patient or Parent/Guardian signature: _____

Parent/ Guardian name Printed: _____

I authorize HoverH, PLLC (Liberty Hill Counseling Center/ Eternal Grace Counseling) to charge my credit card on file for any amount/fee owed to my credit card.

Patient or Parent/ Guardian Signature: _____ Date: _____