FINANCIAL INFORMATION FORM

PLEASE PRINT – COMPLETE ALL SECTIONS

DATE: ________________________ **CASE NO: _____________ (Office Use Only)**

Patient Name:		**Birthdate:**	
Parent/Guarantor Name:		**Gender: M F**	
Social Security Number:	**Email address:**		
Patient Address:	**City:**	**State:**	**Zip:**
Primary Phone #:	**Secondary Phone #:**		
Marital Status (circle one): Single Married Widowed Divorced Separated			
Employer Name:			

INSURANCE INFORMATION

Primary

Insurance Company:	**Insurance Phone Number:**		
Insurance Address:	**City:**	**State:**	**Zip:**
Name of Subscriber:	**Patient relationship to Insured:**		
Subscriber/Policy #	**Group #**		
Subscriber's Date of Birth:	**Effective Date of Coverage:**		

Secondary

Insurance Company	**Secondary Insurance Phone Number:**		
Insurance Address:	**City:**	**State:**	**Zip:**
Name of Subscriber:	**Patient relationship to Insured:**		
Subscriber/Policy #	**Group #**		
Subscriber's Date of Birth:	**Effective Date of Coverage:**		

PLEASE CHECK APPROPRIATE BOX:

☐ **I have insurance and have provided the information above.**

It is important that you inform us of ALL insurance companies you have coverage under, as well as informing us about any change in coverage that may occur while receiving services. If there are claim denials by your insurance company because you did not give us correct information or gave us incomplete information, you will be billed for those services.

☐ **I do not have insurance and do not plan to apply for insurance. I understand I will be billed full cost for services received. For group sessions, payment is due at time of service.**

Please review the poverty guidelines on reverse side, you may be eligible for insurance through BadgerCare or the Federal Marketplace based on your income and family size.

A monthly payment plan is available if needed. Please call 262-284-8200 or stop at the reception area on 3rd floor for assistance.

1. I understand that I am responsible for charges not covered or reimbursed by the above insurer. This includes annual deductibles, co-insurance, copayments, non-covered services, and out-of-network fees. Copays will be collected before services are rendered. It is my responsibility to contact my insurer to determine services covered or not covered.

2. I hereby authorize my insurance carrier to release information regarding my coverage to Ozaukee County Department of Human Services.

3. I hereby authorize payment of medical insurance benefits due me (or my dependent) to be made directly to Ozaukee County Department of Human Services. The assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Ozaukee County Department of Human Services.

4. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. If I do not have any insurance benefits, or after my insurance company has processed claim(s), I understand that I am still liable for the remaining balance of my account. Should my account be referred to collection, I will also be responsible for reasonable attorney’s fees and collection expenses. I understand that my financial and insurance status will be reviewed periodically in accordance with Wisconsin Administrative Code, DHS 1. I assure that the above information is true and correct as of the date signed below.

____ ______________________________
Signature of Patient or Responsible Party **Date**

____ ______________________________
Witness **Date**

This form will remain in effect until discharge from all services or notified of any changes.