LiveWell Group
7781 Cooper Road
2nd floor Suite 5
Cincinnati OH, 45242

Financial Information Form

I truly appreciate your choosing to come to LiveWell Group LLC for psychological help. As part of providing high-quality services, we need to be clear about our financial arrangements.

• If you have health insurance, it may pay for a part of the cost of your treatment here. To find out if this is so, we need the information requested below. We will explain any part of this form that you do not understand.

• If you have no health insurance coverage, or do not intend to use it, please check here ☐, complete sections A and E below, and return this form to your therapist.

A. Patient's name: _____ Birthdate: _____ Soc. Sec. #: _____

Address: _____ Home phone: _____

(If the patient is a dependent) Insured's/policy holder's name: _____

Occupation: _____Employer: _____Work phone: _____

Address of employer:_____

B. (If applicable) Spouse's name: _____Birthdate: _____ Soc. Sec. #: _____

Occupation:_____ Employer: _____Work phone: _____

Address of employer:_____

C. If you (or your spouse) have insurance, please fill in the number and name

Commercial health insurance carrier/company

Name of company: _____Name of policyholder (if not the patient): _____

Policy #: _____ Certificate #: _____

Group or enrollment #: _____ Plan #/code or BS #: _____

Effective date: _____ Phone: _____

Address to send claims: _____

D. For insurance you intend to use, please complete the below information. The information will come either from your company's benefits office or from the insurance company. Then, when we have this information, we have to examine the treatment choices allowed by the coverage you have.

Company: _____ Effective date of coverage: _____

Deductible: $ _____ ❑ per person or ❑ per family? or ❑ per diagnosis? ❑ per fiscal year or ❑ per calendar year or ❑ per policy year?

How much of this deductible has been used so far? $ _____

Benefit: _____ %of ❑ charges ❑ Usual, customary, and reasonable (UCR) ❑ Maximum charge of $ _____

❑ Other benefits:

Percent reduction, if any, for mental health? _____ %

Limitations: Number of visits: ___ Monetary limits: $ _____ per _____ Lifetime limits: $ _____

Is outpatient group psychotherapy covered? ❑ Yes ❑ No

Must a physician refer the client? ❑ Yes ❑ No

Is psychological testing covered? ❑ Yes ❑ No

Does any rule about preexisting conditions apply here? ❑ No ❑ Yes, and the rule is: _____

Are there any other limitations (such as conditions not covered, service settings, maximum per-session charges, need for diagnosis)? _____

_____

_____

E. If you do not have insurance, how will you pay for services from this office? _____

F. I give this office permission to release any information obtained during examinations or treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.

G. I understand that I am responsible for all charges, regardless of insurance coverage.

H. Assignment of benefits

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the therapist above. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.

_____ _____

Client's (or parent/guardian's) signature, indicating agreement to all of the statements above

Date

_____

Printed name