Crossroads Counseling Center, Inc. **INSURED/RESPONSIBLE PARTY INFORMATION**

Please print clearly and provide a copy of your insurance card (front/back) to your provider. Today's Date: _____

Client Name: First _____ Middle _____ Last _____ Date of Birth: _____

Name of Insured/Responsible Party: First _____ Middle _____ Last _____

Insured/Responsible Date of Birth: _____ SSN (last 4 digits):_____Relationship to Client:_____

Physical Address: _____
Street (No PO Boxes)

_____
City *State* *Zip Code*

Mailing Address: _____
Street

_____
City *State* *Zip Code*

Home Phone # (*including area code*): _____ Cell Phone #: _____ Other Phone#: _____

Occupation: _____

Name of Employer: _____ Employer Phone #: _____

Employer Address: _____ _____ _____ _____
Street *City* *State* *Zip Code*

Do you have insurance? ☐ Yes ☐ No, I will be paying for these services myself.

Insured's Primary Insurance Company: _____

Member ID or Medicaid#: _____ Group # (if applicable): _____

Provider or Mental Health Services Phone # (from back of card): _____

Billing Address (from back of card): _____
Street or PO Box

_____
City *State* *Zip Code*

Do you have any additional Insurance coverage? ☐ Yes ☐ No

Insurance Company:_____ ID or Medicaid #: _____ Grp #: _____

Is this a Job-Related Injury/Workmen's Compensation claim? ☐ No ☐ Yes, Company:_____

Please read and acknowledge the following Payment/Insurance Policies:

- I understand that any amount owed by me for services provided are payable on the day/time service is delivered.
- I understand it is my responsibility to pay any deductible, co-pay, or co-insurance amount required by my primary insurance plan on the day and time service is provided, unless those costs are covered by another insurance plan or payer.
- I understand that I am responsible for the full amount of my bill for services.
- I understand that CCC only accepts the following forms of payment: cash, cashier's check or money orders.
- I understand that in the event that my account goes to collections, there will be a **30% collection fee** added to my balance.
- I authorize the use of this form with all insurance claims submitted on my/my child's behalf.
- I authorize the release of information to my insurance company(s) for the purpose of obtaining payment for treatment.
- I authorize direct payment to Crossroads Counseling Center, Inc. by my insurance company(s).
- I authorize a copy of this form to be used in place of the original.

Printed Name Signature Date

<u>24-hour Cancellation Policy for Outpatient Therapy (non-Medicaid clients)</u>: To avoid being charged a "No Show Fee" of $25.00, appointments must be canceled 24 hours in advance of the scheduled date and time of the appointment. Please call the Office between the hours of 9 am to 5 pm, Monday through Friday, to cancel and reschedule appointments. Sign below to acknowledge that you have read and understand the 24-hour Cancellation Policy.

Signature: _____ Date: _____