Second Chance Counseling Services
19733 Executive Park Circle
Germantown, Maryland 20874
Office:240.751.2034 Fax:301.560.3454

FINANCIAL INFORMATION FOR ADULT

Date:____________________ Patient Number:____________________________________

Patient's name: ________________________________ Date of birth: ________________________

Full Address:____

Insurance:__________________________Insurance phone Number:__________________________

Policy/Group number:____________________________ Pt Id Number:___________________

Name of policy holder:___________________________ Date of Birth:____________________

Policy holder's relationship to patient:____

Address (if different from patient):____

Employer: ____

Please list other insurance coverage and #:____

Will you need a statement of expenses for a flexible spending account? Yes O NoO

AGREEMENT FOR PAYMENT AND AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I understand that any co-payment, co-insurance, or out of pocket payment is due at the time services are rendered. I understand that I am expected to give notice 24 hours in advance if I cancel my appointment. If you do not give advance notice and miss or cancel my appointment, I may be charged $40.00. My insurance company will not reimburse me for the cost of a missed appointment. I understand that the Second Chance Counseling Services can give me an estimate of my insurance costs, but that the final decision is up to my insurance company.

I hereby authorize the Second Chance Counseling Services to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company to be made directly to the Second Chance Counseling Services. I certify that the information I have reported with regard to my insurance coverage is correct. I understand that the Second Chance Counseling Services may release necessary information for this or any related claim to my insurance company. I permit a copy of this authorization to be used in place of the original.

_____________________________________ _____________________________________

Insured/authorized person Date SCCSvcs representative Date