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

FINANCIAL INFORMATION FOR CHILD

Date Phone Number

Child's Name Date of Birth

Mother's Name Date of Birth

Full Address

Father's Name Date of Birth

Address (if different)

Employer

Insurance: _____ Insurance phone number:_____

Policy/group number:_____ Patient ID number:_____

Policy holder:_____ Relationship:_____DOB:_____

Please list other insurance coverage and #: _____

Will you need a statement of expenses for a flexible spending account? Yes O No O

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 child's appointment. If I do not give advance notice and miss or cancel my child's 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 Svcs. 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 child's 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.

_____ _____

Parent/guardian's signature Date SCCSVCS representative

Therapist: please indicate diagnosis:_____ Amount paid at intake_____