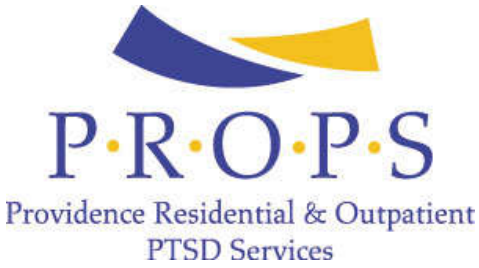

Providence Residential & Outpatient PTSD Services, LLC dba PROPS
and
Felicia Berry-Mitchell, PhD

Financial Information Form

We truly appreciate your choosing to come to us 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.

A. Patient's name: _____DOB: _____Soc. Sec. #: _____
Address: _____Home phone: _____
(If the patient is a dependent) Insured's/policy holder's name: _____DOB_____

Occupation:_____Employer: _____Work phone: _____
Address of
employer:_____

B. (If applicable) Spouse's name: _____DOB: _____Soc. Sec. #: _____

Occupation:_____Employer: _____Work phone: _____
Address of
employer:_____

C._____
Name of Person Responsible for Payment Their Address Their Phone #

D. If you (or your spouse) have any of these kinds of insurance, please fill in the numbers and names for each one.
1. Blue Cross/Blue Shield
Name of subscriber (if not the patient):
_____
Identification/agreement/policy #: _____Group or enrollment #: _____
Plan #/code or BS #: _____ Effective date: _____
Location of plan: _____ Reciprocity #_____
Phone: _____ Other information_____

2. Other commercial health insurance carrier/company
Name of company: _____
Name of policyholder (if not the patient): _____
Policy #: _____ Certificate #: _____
Phone: _____ Address to send claims: _____

3. Government health coverage (Medicaid, Medicare, Tricare, etc)
Name of Insurance:_____
Name of insured (if not the patient): _____
Authorization #: _____ Agreement #_____
6. Workers' compensation insurance
Name of company: _____Policy #: _____
Certificate #: _____
Address to send claims: _____Phone: _____
Treatment authorized by: _____Date of injury: _____

6. Do you or your spouse have any other insurance coverage that applies here (Worker's compensation, motor vehicle in-surance for an injury, etc.)? If yes, check here ❑ and fill in an empty section above.

_____

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. _____
Initial here

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

H. I understand that no records will be sent from this office or released if there is any outstanding balance on my account. I may request a fee schedule at any time for documentation fees, which must also be paid in advance of transmission or release of any records. _____
Initial here

I. I understand there is a 24 hour no show cancellation policy and I will be charged a fee of $100 if I do not cancel my appointment prior to this time M-F 9-5 & $150 on the weekends and evenings. I may also be charged for late appointment arrivals more than 15 minutes after the start of my scheduled appointment ($50). I have signed and received a copy of the credit card authorization form which permits PROPS and Dr. Berry-Mitchell to automatically charge this fee to my credit card for such no show or appointments cancelled within 24 hours. _____
Initial here

J. 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