Hope Behavioral Health, LLC

Financial Sheet

CLIENT's Name _____

CLIENT's Date of Birth_____/_____/_____

HEALTH INSURANCE INFORMATION

Insured Name (Name of policy holder, if different from Client): _____

Insured DOB (of policy holder, if different from Client): _____

Insurance Company: _____ In-Network ___ Out- of- Network ___

Policy (ID)#: _____ Group (MMIS) #: _____

Co-Pay Amount: _____ Copy of Insurance card (both sides) attach: _____

Is Preauthorization required? __ Yes __ No

If Preauthorization is required, please complete the following:

Primary Care Physician Name: _____

Primary Care Physician Telephone Number: _____

If you receive coverage from another health Insurance (e.g. Medicare, Medicaid, etc.**) please provide the information below:**

Insured Name (Name of policy holder, if different from Client): _____

_____

Insured DOB (of policy holder, if different from Client): _____

Insurance Company: _____ In-Network ___ Out- of- Network ___

Policy (ID)#: _____ Group (MMIS) #: _____

Co-Pay Amount: _____ Copy of Insurance card (both sides) attached: _____

Is Preauthorization required? __ Yes __ No

If Preauthorization is required, please complete the following:

Primary Care Physician Name: _____

Primary Care Physician Telephone Number: _____

Hope Behavioral Health, LLC

Financial Sheet (con't)

I authorize Hope Behavioral Health, LLC to bill my health insurance for provided services.

_____ _____

Client Signature **Date**

_____ _____

Parent/Legal Guardian (if a minor or under 26 years of age and covered by parents insurance) **Date**

Is there any financial hardship Hope Behavioral Health, LLC needs to be made aware of and if consideration for a sliding scale rate is being requested?

If yes please explain:

_____

_____

_____

_____