AUSBORN BEHAVIORAL CARE, PC
Financial Information Form

Client's Name: _____ Date ___/___/___ File #: _____
Address _____ Phone: _____ Work: _____
_____ SSN: _____ Date of Birth: ___/___/____
Name of Employer: _____
Address of Employer: _____ Position/Title: _____
_____ Supervisor: _____
Do you have health insurance coverage? Yes _____ No _____
Do you intend to use it to pay for services? Yes _____ No _____
If no, how do you intend to pay for services? _____
_____
If yes, please complete the following:
Insurance Information:
Insurance Company: _____Blue Cross/Blue Shield _____CHAMPUS/TriCare _____Medicare
_____Aetna _____Cigna _____Magellan _____United Behavioral _____Amerigroup
_____Cenpatico _____Other _____
Policy #: _____ Enrollment/plan/group number _____ Effective date ___/___/____
Calendar year deductible $_____ Deductible year starts: _____
Deductible met for year? Yes_____ No _____
Co-payment required Is outpatient group therapy covered? Yes_____ No_____
Must referrals be made by a primary care physician or other gatekeeper? Yes_____ No_____
Any exclusions or limitations affecting this therapy, including number of sessions, types of therapy excluded from coverage _____
_____
Name of policyholder, if different from client: _____
Client's relationship to policyholder: _____
Pre-approval or pre-authorization required? Yes_____ No_____
Pre-approval for specific provider? Yes_____ No_____
Pre-approval authorization number: _____
Number /Type sessions pre-approved: _____

I grant this agency permission to release any information obtained during assessments or treatment which is necessary to support insurance claims for my/our treatment. I understand that I am responsible for all charges regardless of insurance coverage.

Client/Guardian Name: _____ **Signature:** _____ **Date:** ___/___/____