DOUGLAS O. JONES, MD
Child, Adolescent & Adult Psychiatry
5040 SW 28th, Suite B
Topeka, KS 66614
(785) 273-6200

INSURANCE INFORMATION

CLIENT

Last Name: **First Name:** **MI:**

Primary Insurance Company:

Street Address:

City: **State:** **Zip:**

POLICY HOLDER

Last Name: **First Name:** **MI:**

Relationship to Client:

Social Security #: **Date of Birth:**

Insurance ID #: **Group #:**

Employer of Policy Holder:

Benefit Information Effective Date: **Benefit Year Begins:**

Pre-Authorization Needed?	Referral Needed?	Network:
◯ Yes	◯ Yes	◯ In
◯ No	◯ No	◯ Out

List any other health coverage or insurance plans:

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INSURANCE INFORMATION

AUTHORIZATION FOR RELEASE OF INFORMATION FOR THE PURPOSE OF HEALTH INSURANCE BENEFITS

I, _____ ,

hereby authorize Douglas O. Jones, MD, to furnish confidential information from my/the client's mental health records to my Insurance Company listed for the purpose of obtaining insurance benefits. If not previously revoked, this consent will terminate upon the completion of a continuous period of treatment and collection of related health insurance benefits.

FINANCIAL POLICIES AND PAYMENT AGREEMENT

I, _____ , DOB _____ ,

for and in consideration of treatment provided by Douglas O. Jones, MD, agree to pay for my treatment under the following terms.

Douglas O. Jones, MD, agrees to bill my insurance company under the terms of my policy. Douglas O. Jones, MD, makes no representation that this particular treatment will be paid for by my insurance carrier. Co-payments and deductibles will be collected at the time of service.

Because of time demands, a psychiatrists' time is valuable and generally scheduled such that missed appointments and late cancellations/arrivals create difficulty. Should you need to miss an appointment or reschedule, please notify the office at least 24 hours in advance. Missed appointments will be billed in full for the expected service if 24 hours notice is not given. I understand that insurance companies do not reimburse for missed appointments.

It will be the client's responsibility to take care of the account if insurance denies payment. If financial hardship occurs that makes it difficult to pay your balance, please discuss the situation as soon as possible with Deby to arrange a payment schedule. For accounts left unpaid for 60 days and no special arrangements established, we will need to terminate services and send the account to collections.

I have read the above financial considerations, have addressed any questions and concerns, and agree to the payment conditions above.

Client/Parent/Guardian Signature: _____ Date: _____