PAYMENT AGREEMENT
FOR PROFESSIONAL SERVICES BILLED TO INSURANCE

Insurance companies will require extensive information regarding the person insured and the treatment provided. Completing this form is an essential step for the offices of Stephen S. Talley, Psy.D. & Pamella J. Talley, LMFT to bill any insurance party. Please fill in this form completely, answering all questions, if you desire to have your insurance billed directly by the office.

In completing this form you are authorizing Stephen S. Talley Psy.D. or Pamella J. Talley, L.M.F.T. or their representatives to disclose the following information and nature of treatment to the insurance company, medical professionals or other professionals required.

The office will bill most major insurance companies as a courtesy, but we do not have any control over your insurance companies' interpretation of their responsibility to pay your bill or when or what type of treatment is authorized. Therefore, the following agreement is with you the patient. You are responsible for your bill.

I understand and agree that I am responsible for the payment of professional services rendered and not my insurance company.

I agree that I will pay 50% of charges or the insurance stipulated "co-payment" at the time of service.

I understand that these payments will continue until insurance reimbursement has been received by Stephen S. Talley, Psy.D. or Pamella J. Talley, L.M.F.T.

I agree that if payment has not been received from insurance after 60 days from first billing to pay a minimum 20% of the outstanding balance and continue with such minimum, payments until my account is paid in full.

My signature certifies that the information in this agreement is true, accurate, complete, understood and agreed to.

Signature:_____ Date:_____
(Guardian if patient is a minor)

INSURANCE INFORMATION

Insurance Company:_____

Address:_____

_____
city state zip

Phone:_____ Fax:_____

Insured Person's Name:

_____
Last First Middle

Address:_____

_____
city state zip

Phone # Hm: _____ Date of Birth:_____

Employer:_____

Phone # Wk: _____ Employee ID #: _____

Social Security #:_____ Insurance ID #:_____

Patient's Name:

_____
Last First Middle

Address:_____

_____
city state zip

Phone:_____ Date of Birth:_____

Social Security #:_____ Insurance ID #:_____

INSURANCE INFORMATION

Patient's relationship to the insured: ___Self ___Spouse ___Child

Name of Family Doctor:_____

Phone number:_____ Location of office:_____

Is this insurance a "managed care" policy? ___Yes ___No

If yes, have you been in contact with them about receiving psychological services?

___Yes ___No ___Not Applicable

If yes, have you received an official authorization for psychological services?
___Yes ___No ___Not Applicable

Date of authorization_____ Authorization #_____

Is this a service provided through an Employee Assistance Program (EAP)?

___Yes ___No ___Not Applicable

If yes, have you received an EAP authorization for psychological services?

Date of authorization_____ Authorization #_____

Is this a group policy? ___Yes ___No

If yes, the group name:_____Group Number:_____

Date policy became effective:_____

Annual Deductible Amount:_____ Amount Paid to date:_____