

Anderson, Arnold and Partners, L.L.P.
INSURANCE PAYMENT AGREEMENT & AUTHORIZATION

By completing this form you are indicating that you do have insurance and you want to have services billed to your insurance company. You are required to make your copayment or deductible payment at the time of service.

PRIMARY INSURANCE INFORMATION

Date: _____

Patient's name as listed with insurance: _____

Patient's status on policy: (circle one)	Self	Spouse	Dependent	Other	
Patient's marital status:	Married	Divorced	Legally separated	Single	Widow
Patient's employment status:	Full-time	Part-time	Not Employed	Retired	Self-Employed
Patient's student status:	Full-time	Part-time	Not a student		

Subscriber's Name (as listed on insurance card) _____ Subscriber's DOB _____ Subscriber's SSN _____

Subscriber's Address: _____ Street, City, State, Zip Code _____

Subscriber's Employer _____ Work Address _____

Home Phone Number _____ Work Phone Number _____

Insurance Company Name _____ Claim Department Phone Number _____

Insurance Company Address _____

Prefix/Policy # _____ Group Number/Name _____

Yearly deductible: _____ Co-payment amount: _____ Annual # of visits allowed: _____

Number of visits pre-certified (if required): _____ Authorization #: _____

Date span of Authorization: _____ Physician Referral required? _____

Do you have secondary insurance coverage? _____ If yes, please fill out secondary insurance form.

Authorization for Disclosure of Mental Health Information

I, _____, on my own behalf or as legal representative of _____ authorize Anderson, Arnold & Partners, L.L.P. to release mental health information, to the full extent specified under Iowa Code Chapter 228, or as subsequently amended, to my insurance company, _____ and to any organization contracting with this insurance company to 1.) administer claims submitted or to be submitted for payment, 2.) conduct a utilization and quality control review of mental health care services provided or proposed to be provided, or 3.) conduct an audit of claims paid.

I acknowledge that I may inspect the information disclosed at any time, and may revoke this authorization at any time if I furnish written revocation to Anderson, Arnold & Partners, L.L.P. In the event I revoke this authorization, I agree to accept financial liability, in writing, for mental health care services provided if _____ or its affiliates or subsidiaries deny claims for benefits because of the inability to examine my mental health records or the mental health records of the person named in this authorization.

This Authorization is valid for all records relating to services provided to me or the person named in this authorization from _____ (date) until treatment ceases.

Authorized Signature

Date