Financial Agreement and Information for Molli M. Wilson, PhD

Please answer the following questions regarding your insurance. If you are unsure, please leave blank. Today's Date_____

Patient's Name_____ DOB__ _____ Ref'd by _____

Parent or Guardian_____

Address_____City/Zip_____

Home phone_____Cell_____Work_____
May I leave a msg? Y or N

Insurance Carrier_____Insurance phone_____

Insured/Subscriber_____DOB_____SSN_____

Policy Holder's Employer_____ID#_____Group#_____

Emergency Contact_____Phone_____

Is the patient covered under this insurance? Yes No Effective Date_____

Are you currently seeing another Mental Health provider? Name_____

Do you have an annual deductible ?_____ Amount?_____Copay amount_____

Is a referral or pre-authorization for treatment needed? Y or N .

E-Mail Address_____

I agree to bill your insurance carrier for you. You remain responsible for any fees your carrier declines to pay. A 1.5% service fee will be applied to the balance after 60 days.
A 24 hour *business* day notice of cancellation is required. Cancellation with less than 24 *business* day notice or failure to keep a scheduled appointment will result in your being charged for the full appointment fee. Insurance companies do not cover this charge.

I have read and understand this agreement between myself and Molli M. Wilson, PhD

_____ _____
Patient Signature (13 or older) Date

_____ _____
Parent or Legal Guardian Date