JEN McVANN, MS LMFT CST

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Billing and Insurance Information

Client Name: _____

Billing Full Name: _____

Billing Address: _____

Billing City: _____ State: _____ Zip: _____

Billing Phone: _____ OK to leave message? ☐ Yes ☐ No

Credit Card Number: _____

☐ MasterCard ☐ Visa ☐ AmEx ☐ Discover Exp. Date: _____ CVV: _____

Note: Policies with a deductible or out-of-network insurance require a credit card on file.

I hereby give consent to charge my credit card for any outstanding balance such as deductibles, copayments, fees, or other amounts my carrier determines payable by me.

Cardholder Signature: _____ Date: _____

Private Pay Clients: Session Rate: $ _____

Insurance (Blue Cross, PreferredOne, and Aetna only)

Primary Insurance Company: _____

ID#: _____ Policy #: _____ Group #: _____

Policy Holder Name: _____ Relationship to Client: _____

Policy Holder's Address: _____

Policy Holder's City: _____ State: _____ Zip: _____

Policy Holder's Phone: _____ DOB: _____

Copay: $_____ Deductible: $_____ Coinsurance: %_____

Secondary Insurance Company: _____

ID#: _____ Policy #: _____ Group #: _____

Policy Holder Name: _____ Relationship to Client: _____

Copay: $_____ Deductible: $_____ Coinsurance: %_____

I am responsible for payment to Jen McVann Therapy, LLC for all services rendered. I authorize the release of any medical information necessary to my insurance to process any claim for services provided. I assign all benefits from my insurance or other third-party coverage to Jen McVann Therapy, LLC, and acknowledge that I am responsible for payment for provided services regardless of reimbursement for these services by my insurance. I also understand that if I suspend or terminate my treatment any outstanding balance will be immediately due.

Signature: _____ Date: _____