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: ______________