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