DIVINE INTERACTIONS EQUINE FACILITATED WELLNESS, LLC

Mailing/Billing:
P.O. Box 165
Avonmore, PA 15618

Phone: 724.567.8988

Practice Location:
276 PA-156
Avonmore, PA 15618

Fax: 724.567.8989

Email: info@divineinteractionsefw.com

CLIENT INFORMATION:

Full name: ____ Date of Birth: ____ / ____ / ______

Home Address: ______________________________ City:____________ State: ____ Zip: _________

Phone: _______________________ Employer or School (if student): _______________________

Referred By: ____ Physician: ___________________________

Person to Contact in Emergency: _________________________________ Phone: ________________________

INSURED/RESPONSIBLE PARTY INFORMATION

Full Name of Insured: _______________________________ Relationship: ____________ Date of Birth: ____ / ____ / ______

Home Address: ____ Phone: _________________________________

City: ________________________ State: _____ Zip: ___________ Employer: _______________________

Insured's Primary Insurance Co.: _______________________________

I.D. No.: ____ Group No.: _______________

Name of Policy Holder_________________________________ Relationship to Client_____________________

Address of Policy Holder____

Policy Holder's Birthdate ________________________

Policy Holder's SSN ____________ Policy Holder's Employer______________________________

I have a secondary insurance policy (please specify).

Carrier Name: ____

ID #:____

***Please initial if you will not be using insurance to pay for services rendered:** Initials____________

RELEASE AND ASSIGNMENT
I authorize the release of any information necessary to process my insurance claims and assign and request payment to my provider. I have received a copy of DIEFW Notice of Privacy Practices.

Client Signature: ____ Date: _________________________

FINANCIAL AGREEMENT
I agree to fully investigate my insurance benefits and take responsibility for paying all amounts not paid by my insurance company. I agree to bring physical payment for copays and all services provided at the time of the office visit.

CO-INSURANCE/DEDUCTIBLE:

If my insurance policy only covers a portion of the amount of each session (i.e., I am responsible for co-insurance, or a percentage of the cost of the session), or if my policy is subject to a deductible that has not been met or any outstanding balances. I agree to bring some form of payment when services are rendered. Please confirm any outstanding balances prior to services. I agree to forfeit my appointment if I come without full payment (self-pay rate, copay, co-insurance, deductible, or any other past-due balance), and agree to compensate the therapist for his/her reserved time, as outlined in paragraph below (with a $50.00 charge) every three weeks for the length of time an unpaid balance remains unpaid, and understand that if my account is unpaid for 60-90 days, my account will go to collections, and that I am responsible for all reasonable costs associated with collection agency and/or legal efforts. I understand that if my account goes to collections, it cannot be removed, and that I cannot be an active client with unpaid balances.

INSURANCE COVERAGE

DIEFW participates with commercial Highmark, UPMC, Optum/United Behavioral Health, Aetna, and Cigna products with the exception of Medicare and Medicaid products within those plans. I can consult with my insurance company to better understand my policy benefits.

OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form on all of my insurance submissions and I authorize the release of information to my insurance company.
2. I have been given information on privacy practices, client rights and responsibilities.
3. I authorize direct payment to my service provider, DIEFW.
4. I understand that I am responsible for any deductible amount, co-pay, co-insurance amount or if paying myself, the full amount of my bill for services provided. I understand there will be a $25 service charge on returned checks.
5. I understand there is a 24-hour cancellation policy and that I must cancel my appointment 24 hours in advance to avoid incurring a "no show"/late cancellation fee.

FOR LATE CANCELLATION/NO SHOW PURPOSES ONLY (REQUIRED): A $50.00 charge will be applied to your account.

Card Type (circle one) VISA MASTERCARD DISCOVER AMEX

Name on Card: ____

Number: ____

Expiration Date: _____/______ 3Digit Code ___________________

Credit Card Billing Zip Code: ___________________

Please note: Health Spending Account debit/credit cards are not accepted for late cancellation/no show fee purposes

Client Signature: ____ Date: _________________________

INFORMED CONSENT

1. I give my authorization and consent to receive outpatient diagnostic and treatment services having discussed the advantages/disadvantages of the recommended treatment.
2. I will address any concerns or grievances with my therapist.
3. I understand that while psychotherapy is confidential, there are limits to my rights to confidentiality, such as situations of danger to myself or another, as well as legal mandates from a judge.
4. I understand that my therapist may seek professional direction and support for my treatment by consulting with a member of their consultation team.
5. I am voluntarily choosing to enter into psychotherapy treatment and may discontinue at any time.

Client Signature: ____ Date: _________________________

I agree to communications via email/text only for scheduling/rescheduling (nonclinical) purposes and understand/accept the risk that they may not be secure.

Client Signature: ____ Date: _________________________