The Atrium
4 Terry Drive, Suite 11, Newtown, PA 18940
Phone: 215-550-1818
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Insurance Information Form

Patient's Information:

Name: ____

Address: ____

Phone number: ____

Date of Birth: ____

Insurance Company: ______________________________ Plan: ___________________________

ID: ____

Group number: ____

Subscriber's Information:

Relationship to patient: ___ Self ___ Spouse ___ Parent ___ Other (please specify_____________)

Name: ____

Address: _______________________________________

Phone number: _________________________________

Date of Birth: ___________________________________

Social Security Number: _________________________

Insurance ID: __________________________________

Policies Regarding Insurance Payment

- By signing this form, you provide Bucks County Anxiety Center permission to use and release your personal health information (PHI) to obtain payment from your insurance carrier or referring agency.
- By signing this form you agree to pay all applicable fees associated with using your insurance such as co-pays, co-insurance, rejected claims or any other type of outstanding balance.
- By signing this form you agree to provide Bucks County Anxiety Center with a credit card number that will be kept on file and will be charged in the event that you do not pay your balance due.
- Co-pays and co-insurance are due at each session. They can be paid by cash, credit card, or check. Checks will be made out to **Bucks County Anxiety Center**.
- You are responsible for all fees that are not paid by your insurance company such as co-insurance or any rejected claims. **Balances must be paid within 2 weeks or your credit card will be charged for the amount you owe.**
- Please contact your insurance company to make sure that services do not require pre-authorization. Please note that pre-authorization does not guarantee that your insurance company will pay for the actual services.
- Please note that not all diagnoses are reimbursed by insurance companies. Diagnoses will not be changed in order to make them more likely to be reimbursed.

Patient Signature: ____ Date: ____________________

Patient's Name: ____ Date: ____________________

Parent/Guardian's Signature: ________________________________ Date: ____________________

Parent/Guardian's Name: ___________________________________ Date: ____________________

Credit Card Information:

Please check off one of the following options and then provide your signature:

____Please charge all co-pays and any other fees to this card. I understand that I will receive a statement anytime the card is charged. Signature: ________________________________

____Please only bill this card in the event that I have an outstanding balance that has not been paid in 2 weeks. I understand that I will always be notified of outstanding balances and will be given a full 14 days to pay my balance before the card is charged. Signature: _______________________________

Name on card: ____________________________

Credit Card Number: ________________________________

Security Code: _______________

Expiration Date: _______________________

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that I can print off a copy of Bucks County Anxiety Center's Privacy Practices from the website. In addition, I hereby consent to the use and disclosure of my and/or my child's personal health information for the purposes of treatment, payment, and health care operations.

Patient Signature: Date:

Parent/Guardian Signature: Date:

Assignment of Benefits

I hereby authorize payment directly to Bucks County Anxiety Center, LLC, and its employees for therapy services provided to me/my child/my family. This is a direct assignment of my rights and benefits under my insurance policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Patient Signature: Date:

Parent/Guardian Signature: Date: