

**HAMBURG COUNSELING SERVICE, INC.**  
**INSURANCE DATA AND FEE SCHEDULE AGREEMENT**

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ADM. DATE \_\_\_\_\_ THERAPIST \_\_\_\_\_

CLIENT NAME (Please Print) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SS# \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ WORK PHONE # \_\_\_\_\_ OK TO CALL? Y N

MARTIAL STATUS – (CIRCLE ONE) Married, Widow, Divorced, Separated, Single

**INSURANCE INFORMATION:** \* Information mandatory

\*NAME OF CARDHOLDER \_\_\_\_\_ RELATIONSHIP: SPOUSE, SELF, CHILD

\*CARDHOLDER DOB \_\_\_\_\_ \*CARDHOLDER SS # \_\_\_\_\_

MEDICAID # \_\_\_\_\_ SEQ# \_\_\_\_\_ MEDICARE # \_\_\_\_\_

INDEPENDENT HEALTH # \_\_\_\_\_ GROUP # \_\_\_\_\_

CO-PAY \$ \_\_\_\_\_ REFERRAL # \_\_\_\_\_ (If none sign waiver)

COMMUNITY BLUE # \_\_\_\_\_ GROUP# \_\_\_\_\_

CO-PAY \$ \_\_\_\_\_ AUTHORIZATION # \_\_\_\_\_ (If none, sign waiver)

UNIVERA HEALTH CARE # \_\_\_\_\_

CO-PAY \$ \_\_\_\_\_ REFERRAL # \_\_\_\_\_ (If none sign waiver)

OTHER INSURANCE – INS. NAME \_\_\_\_\_

ID # \_\_\_\_\_ GROUP # \_\_\_\_\_ CO-PAY \$ \_\_\_\_\_

**If you do not have insurance**, a portion of our services may be paid, if you need, but cannot afford mental health care. This financial contribution (from New York State, the Town of Eden, and your neighbors' donations) is based on your Gross Annual Income. Services will be withheld for failure to make payment until you make a repayment schedule with the Director.

TOTAL YEARLY GROSS INCOME OF THE HOUSEHOLD \_\_\_\_\_  
FEE FROM SLIDING FEE SCHEDULE \$ \_\_\_\_\_ PER SESSION

**PAYMENT IS DUE WHEN SERVICES ARE RENDERED**  
**THERE IS A \$30.00 CHARGE FOR EACH MISSED APPOINTMENT NOT CANCELLED AT LEAST 24HRS. IN ADVANCE**

In signing this form:

- I agree that payment for services at Hamburg Counseling Service will be made as indicated above.
- I hereby authorize release of necessary billing information to my insurance carrier.
- My signature below acknowledges that I have been informed of Hamburg Counseling Services, policies on my rights and fees for services. I understand that I may report any grievance to the Executive Director. I have received this information in writing.
- I have received a copy of the service agreement explaining HIPAA policies regarding privacy and information security.

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
CLIENT SIGNATURE

\_\_\_\_\_  
DATE