Judy Hait, LMFT, PLLC
Counseling for Individuals & Couples AAMFT Approved Supervisor

INSURANCE INFORMATION

Client Name: ____________________________ Birthday (M/D/YY): ______________

Name of Person Insured: ____________________________ Birthday (M/D/YY): ______________

Insurance Company: ____________________________ Phone number for insurance:______________

Address for Insurance (back of card): ____________________________

ID Number on Card: ____________________________Group Number: ______________

Employer: ____________________________

Deductible: ____________ Has the deductible been met? ☐ Yes ☐ No

Fee Without Insurance: $120

Co-Pay Due at Each Session: ______

No Show Fee: $120

Consumer Responsibility Statement

- I understand that my portion of the fee (co-pay) is due at time of service.
- I understand that a no show fee will be charged for appointments cancelled without 24 hours notice. Because insurance does not pay for missed sessions, I will be responsible for the full fee, not just the co-pay.
- I understand that I am responsible for paying my deductible and any amounts not covered by insurance.
- I understand that if, for any reason, my insurance company does not pay my fee, I am responsible for the entire amount.
- I authorize the release of information needed to verify and process insurance claims to Judy Hait, MS.

____________________________ ____________________________

Person Responsible for the Account *Date*