11920 Sawhill Blvd., Spotsylvania, VA 22553
Ph 540-317-1165 Fax 540-301-5657

BILLING INFORMATION SHEET

Patient Name:_____

Responsible Party Information

Responsible Party Name: _____

Relationship to patient: _____

Address: _____

_____

Home Phone Number: ( )_____

Work Phone Number: ( ) _____

Cell Phone Number: ( ) _____

Employer: _____

I do not participate with any insurance plans, however, some insurance plans reimburse for "out of network" licensed professional mental health providers. You are required to pay at time of service, and at your request, I will provide a form with diagnostic codes needed to file a claim directly with your insurance company for reimbursement. Please check with your insurance company for "out of network" benefits specific to your coverage.

If you are unable to keep your appointment, please give me 24 hours notice or you will be charged the amount for a full session. Thank you.

Patient or Responsible Party

Signature_____ Date _____