Heidi Wilson LLC, LPC

The Atrium, 4 Terry Drive, Suite 3, Newtown, PA 18940
heidi_lpc@outlook.com 267-399-0002

Financial Policy & Consent for Billing

Name (First, MI, Last):_____ Gender: Male Female

Date of Birth:___/___ /____ Social Security #: _____ - ____ - _____ Marital Status: Single Married

Mailing Address:_____

City/State/Zip: _____

Street Address (if different from above): _____

City/State/Zip Code: _____

Phone (Home):_____ Phone (Cell): _____

Email: _____

Primary Care Provider: _____

Insurance Information* (fill out completely)

Primary Insurance:
Insurer ID#:
Group#:
Claims Address:
Subscriber:
Subscriber's Date of Birth:
Copay (for specialist):
Secondary Insurance (if applicable)
Insurer ID#:
Group#:
Claims Address:
Subscriber:
Subscriber's Date of Birth:

Payment Policy: We ask that you read through the financial policy and sign the bottom prior to treatment. Co-pays are due at the time of service, or full payment is due for self-pay patients unless prior arrangements have been made with our billing department. We accept cash, credit cards, or check payable to Heidi Wilson LLC. There is a $25 return check fee with no exceptions.

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Insurance: Our office will kindly bill your insurance company. We participate with a number of medical insurance plans that we will contact to verify eligibility and benefits. Please realize that you have the ultimate responsibility of verifying the coverage with your insurance. You acknowledge that we may be an out of network provider with your insurance. You are also aware that in some circumstances your insurer will send payment directly to you. You agree to endorse the insurance check and forward funds to the appropriate entity above within 30 days of receipt. You will be responsible for any balance not paid or denied by your insurance carrier. Patients who do not supply accurate insurance information will be considered self-pay. You must inform our office of any changes in your insurance, as you are the policyholder and it is your responsibility.

Insurance Referrals: If your plan requires a referral from your Primary Care provider, it is your responsibility to obtain it before seeking treatment from us. If a claim is denied due to a lack of referral you will be responsible for charges. You understand that you are financially responsible for claims denied or not covered by your insurance carrier for failure to obtain a referral.

Missed Appointments: If you are unable to keep your appointment you must notify the office at least 24 hours prior to your scheduled appointment as courtesy to the doctors, staff and other patients. If you cancel or "no-show" without sufficient notice, you may be subject to a fee, payable by you, not your insurance company.

Please let us know if you have any questions regarding our Financial Policy. The above information on all pages of this document is thorough and accurate to the best of my knowledge. For any changes to the above information, I will notify the office. I consent to evaluation and treatment by Heidi Wilson LLC.

I hereby authorize release of medical information that is necessary for my further treatment. I authorize release of information, including treatment and protected health information to my insurance company that is needed to process payment for services. I authorize my insurance carrier to pay benefits for services rendered, directly to Heidi Wilson, LLC or any of its affiliates. I have read and agree to the terms of the above information. I understand payment is expected at the time services are rendered and that I am responsible for any balance.

Patient Name (Please print):_____Date of birth: _____

PATIENT/Authorized Person SIGNATURE: _____

Authorized Person NAME (print): _____Relationship:_____

Date: _____