Spiezio and Affiliates

Annette M. Spiezio, LCPC - President

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Financial and Authorization Policy

Date: ____________

Client Name:____

Client Date of Birth: ____/_____/________

Client Address:_________________________________City:______________State:____Zip:___________

Member ID:___________________________

Group Number _____________________ (If Applicable)

Regarding Insurance

We may accept assignment of insurance benefits. It is your responsibility to verify whether Spiezio & Affiliates (Annette Spiezio) is a participating provider with your plan. In accordance with your insurance provider co- pays and deductibles are to be paid prior to service. You are responsible for the balance whether your insurance company pays or not. We cannot bill your insurance company unless you give us your correct insurance information.

Please be aware that some, and perhaps all, of the services provided may be non-covered services under your medical insurance. A copy of your insurance card will be made at your first visit and must be updated whenever you insurance coverage changes.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our clients. You are responsible for payment regardless of an insurance company's arbitrary determination of usual and customary rates.

Pre-Certification

It is the responsibility of the client to make sure prior authorization is obtained and the client is financially responsible if the pre-certification is not obtained.

Minor Clients

The parent(s) (or guardians of the minor) are responsible for full payment.

Authorization and Release

I request that payment of authorized insurance benefits be made on my behalf to Annette Spiezio for any services rendered to me. I authorize Annette Spiezio to release medical information about me to determine benefits payable for related services. I hereby give consent to Annette Spiezio to review or discuss pertinent aspects of my treatment relevant to my medical care to any physician, hospital and/or health professionals as necessary.

I have read the Financial & Authorization Policy. I understand that I am responsible for all charges not paid by my insurance company. Please let us know if you have any questions or concerns.

I understand that this Authorization shall apply to all services provided to me, my dependents, or any other person for which I have assumed responsibility by signing below, for this date forward until revoked in writing.

Client Signature: ____ Date: _____/____/_____

Responsible Party:_______________________________________ Witness:_________________________