# *Forward Motion* – **Therapy Services Billing Form** (one form per primary patient & each associate patient in any sessions) Case #FM_____

☐ Primary Patient or ☐ Associate to (PP Name): _____

Name: _____

Birth Date: _____ Age: _____ Gender: M F

Patient Home Address: _____

City, State, Zip: _____

E-Mail: _____
May we use email to send messages? Yes ☐ No ☐

Your Employer: _____

Primary Phone: _____
May we leave a message? Yes ☐ No ☐ May we use texting? Yes ☐ No ☐

Secondary Phone:_____
May we leave a message? Yes ☐ No ☐ May we use texting? Yes ☐ No ☐

Work Phone:_____
May we leave a message? Yes ☐ No ☐ May we use texting? Yes ☐ No ☐

Associate Patient Categories: List With Relationship
(Spouse, Partner, Children, Parent, Siblings, Other)

Birth Dates:

(Please also provide separate form for each. Thank you.)

PRIMARY INSURANCE N/A ☐

Ins. Co. Name:

Ins. Co. Phone:

Name of the person Insured (primary carrier):

Address of this Insured (☐ Same as patient address):

| CoPay $_____
| or _____%

Date of Birth of Primary Insured: _____

ID number of Insured: _____

Group number : _____

SECONDARY INSURANCE N/A ☐

Ins. Co. Name:

Ins. Co. Phone::

Name of the person Insured (secondary carrier)

Address of this Insured (☐ Same as patient address):

| CoPay $_____
| or _____%

Date of Birth of Secondary Insured: _____

ID number of Insured: _____

Group number : _____

PROVIDER COMPLETES THE FOLLOWING

Payment for Services: ☐ Cash, ☐ Check, ☐ Card

Provider is In-Network Yes ☐ No ☐

Patient intake fee 90971: $ 190.00

Patient fee 90834: (45" Session) $ 115.00

Patient fee 90837: (60" Session) $ 135.00

Patient fee 90846/47: (Family Session) $ 135.00

Patient other ( ) $ _____

Pre-payment $ _____

Verified Co-pay Info: _____

☐ Co-pay is deferred pending payment schedule.

☐ Patient will make co-pay when able.

☐ Financial hardship:

Discount 1 _____

Discount 2 _____

HOW DID YOU LEARN OF MY SERVICES?

☐ Payer's Provider List; ☐ Internet Search;

☐ Yellow Pages; ☐ Forward Motion Wed Site

☐ Other: _____

EMPLOYEE ASSISTANCE PROGRAM N/A ☐

Company Name:

Authorization Info:

- Payment is due at the time of each appointment. I agree to pay my out-of-pocket obligation by cash, check, or card by end of each meeting. Otherwise, I authorize the use of my credit, debit, or health savings account card as permitted above to pay unpaid balance. I understand that I will be invoiced for my unpaid balance. Initial: _____ N/A ☐
- I authorize the release of any health information necessary to process third-party payment claims. This release of information expires in six months. Initial: _____ N/A ☐
- I authorize my third-party payer to directly pay benefits to the provider of services. I understand that I am fully responsible for fees not covered. Initial: _____ N/A ☐
- I was offered a copy of the Forward Motion HIPAA notice and other policies. Initial: _____

**Signature (Responsible Person)** _____ **Date** _____

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