Client Updated Information 2019

Please read over and complete our 2019 Client Updated Information Form.

Please fill out the form in its entirety as we use this to keep our records up to date. We know that your information may not have changed from the previous year but we still ask that you fill in the information on the form and do **not write "same".** Please be advised that if we do not have current insurance information at the time of service, the appointment will be billed at the private pay rate and a statement will be sent for payment.

Please call the number on the back of your card to make sure a prior authorization is not required for mental health services. If so, please obtain and write the number in the space provided on the other side of this form. Lots of plans have changes in benefits or new plan exclusions and limitations at the start of the new plan year. You will want to ask the representative specifically about your "outpatient mental health benefits".

Compass Point strives to keep our clinicians in network with as many insurances as possible. If your insurance is changing for 2019 please call your insurance and check to make sure your clinician is in network with your new plan. In addition we are still not in network with any Medicaid policies.

We are also offering you the option to keep a credit card on file to pay for your appointments. We will **only** charge services rendered to your card. Your card will **NOT** be charged in the event that you are assessed a "late cancel" or "no show." However, we do ask that you pay these charges in a timely manner.

If you have any questions about the form or this letter, please don't hesitate to call the office at 513.939.0300.

You can turn this form into any office personnel, your therapist, bring it to your next appointment or

MAIL IT: 1251 Nilles Rd, Suite 5, Fairfield, Ohio 45014
EMAIL IT: info@compasspointcounseling.net
FAX IT: 513.939.0310

CLIENT FULL NAME ______________________________ TODAY'S DATE ______________
FIRST MI LAST

SS#/SIN ____________________ AGE _________ BIRTH DATE ______________ THERAPIST ______________

If client is a minor please verify the responsible party's information:

FULL NAME ______________________________ ☐ Male ☐ Female
FIRST MI LAST

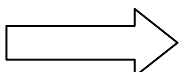
SS#/SIN ____________________ AGE ______ BIRTH DATE ____________ RELATIONSHIP TO CLIENT ___________

____
STREET/APT CITY STATE ZIP CODE

HOME PHONE________________ CELL PHONE__________________ EMAIL ______________________________

*is it okay to call or leave a message at home? ☐ Yes ☐ No *is it okay to send email? ☐ Yes ☐ No

*is it okay to call or leave a message on your cell? Yes☐ No ☐ *is it okay to send text message ☐s N☐

PLEASE FLIP OVER TO COMPLETE OTHER SIDE 

Client Updated Information
2019

INSURANCE INFORMATION (complete all spaces below even if information is the same)

If your insurance plan is through Medicaid we are NOT in network. Please verify with insurance PRIOR to being seen.

NAME OF INSURED_________________________ RELATIONSHIP TO CLIENT________________DOB ___________
FIRST MI LAST

____
STREET/APT CITY STATE ZIP CODE

SS#/SIN ________________ NAME OF EMPLOYER _______________________ Auth number (if needed):__________

INSURANCE COMPANY ________________________ MEMBER ID# _________________________________

GROUP #__________________ PROVIDER SERVICES PHONE (Located on back side of card) ___________________

Does the client have any additional insurance? ☐NO ☐YES, please complete the following:

SECONDARY INSURANCE

If your insurance plan is through Medicaid we are NOT in network. Please verify with insurance PRIOR to being seen.

NAME OF INSURED_________________________ RELATIONSHIP TO CLIENT______________DOB _____________
FIRST MI LAST

____
STREET/APT CITY STATE ZIP CODE

SS#/SIN ________________ NAME OF EMPLOYER _______________________ Auth number (if needed): __________

INSURANCE COMPANY ________________________ MEMBER ID# _________________________________

GROUP #__________________ PROVIDER SERVICES PHONE (Located on back side of card) ___________________

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CREDIT CARD BILLING RECORD

CLIENT NAME ____________________ CARDHOLDER NAME _________________ RELATIONSHIP __________

CREDIT CARD NUMBER ___________________ EXPIRATION DATE __________ SECURITY CODE ____________

CARD IS A: ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMERICAN EXPRESS

☐ I WOULD PREFER TO OPT OUT AND INSTEAD MAKE PAYMENTS ON MY ACCOUNT AT THE TIME OF SERVICE

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AUTHORZATION & RELEASE

I understand that I have given Compass Point Counseling Services permission to charge my credit card. I also understand that if my insurance applies any amount to my deductible or denies payment, the full amount of the visit will be billed to my credit card. These charges will happen automatically unless I chose to opt out above.

I understand that if Compass Point does not have current insurance information at the time of service, the appointment will be billed at the private pay rate and a statement will be sent for payment. I also understand that if a denial or insurance issues arise that it is my responsibility to pay the balance in full or to work with my insurance company to remedy the problems.

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the therapist.

X____
Signature of client (or responsible party if minor)