Debora J. Hayden, MSW, LCSW

655 Craig Road, Suite 128 Saint Louis, Missouri 63141

Phone: 314-989-9449 Fax: 314-989-9333

**Billing Information**

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Payment in full is requested at each appointment unless other arrangements are made. I understand that appointments must be cancelled 24-hours in advance, otherwise I will be charged $65 for the missed appointment. If a collection agency becomes involved there will be an additional recovery fee charged. If using insurance, a claim will be submitted following each appointment.

**Private Pay:** You have the right to not utilize your insurance benefits. By paying “out of pocket” you have more control over your personal mental health information.

I understand I am solely responsible for all financial charges regardless of potential insurance or third-party reimbursement, as well as any charges incurred by missed appointments or late cancellations.

**Payer Source: Insurance ( ) Private Pay ( ) Private Pay Fee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_** (per session)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Guardian Signature Date

**Insurance Authorization**

**Insurance(s):\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Authorization # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Authorization # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Subscriber’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Subscriber’s DOB: \_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Subscriber’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I hereby authorize my insurance company to pay medical insurance benefits directly to Debora J. Hayden, MSW, LCSW for services rendered, and to release any medical and/or mental health information regarding the above-named client necessary to process claims. I understand I am financially responsible for any required copays, deductibles, or services not covered by my insurer.

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Client/Guardian Signature Date

**Credit Card Authorization**

Cardholder name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Card Type: ( ) Visa ( ) Mastercard ( ) Discover ( ) American Express

Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize you to charge my credit card for current balances.

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Card Holder’s Signature Date