William M. Boylin, Ph.D.

Individual, Marital and Family Psychotherapy

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Middlefield, CT. 06455
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Payment Information

Self Pay Y / N **Insurance Y / N**

IF YOU CHOOSE TO PAY FOR SERVICES BY ACCESSING YOUR MENTAL HEALTH BENEFITS UNDER YOUR MEDICAL INSURANCE, COMPLETE THE FOLLOWING:

Insurance Company Name: _____

Name of Subscriber (if different than the client's):_____

ID #: _____ **Group Number**: _____

Subscriber SS # _____-_____-_____ DOB of Subscriber:_____

Employer: _____

Mental Health Benefits Telephone Number (Please see back of card):

_____

COPAY: _____ (Copays are to be paid at the time of the session.)

AUTHORIZATION # _____

(If you have not obtained an authorization you must do so today-please call the office with the authorization #, start date, end date and # of sessions.)

Missed and less than 24 hour cancelation appointments are not covered by INS and will be billed directly to the client or responsible party.

Your signature below allows this office to provide clinical information, which includes such information as dates and types of services provided, diagnosis, progress toward treatment goals, and so forth, to your health insurance carrier(s) for the purposes of obtaining payment for services rendered:

_____

Signature Date

Revised: 1/1/13 WmB