Bridget Fanning-Ono, Psy.D.

Billing Information Form

Patient Information - If the financially responsible person is other than the patient, please complete page 2 of this form.

Patient Name: _____ DOB: _____

Gender: M__F__ Other__ Marital Status: _____ SSN: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cellular: _____ Email: _____

May messages be left for you at home? _____At work? _____ Cell? _____ Email? _____

Insurance Information - Please provide a copy of your insurance card(s), front and back.

Primary Insurance Carrier: _____ Phone: _____

Claims Address: _____ City: _____ Zip: _____

Name of Insured: _____ Relation to Patient: _____

Insured ID Number: _____ Group Number: _____

Insured DOB: _____ Phone: _____Employer: _____

Insured's Address: _____ City: _____ Zip: _____

Secondary Insurance Carrier: _____ Phone: _____

Claims Address: _____ City: _____ Zip: _____

Name of Insured: _____ Relation to Patient: _____

Insured ID Number: _____ Group Number: _____

Insured DOB: _____ Phone: _____Employer: _____

Insured's Address: _____ City: _____ Zip: _____

Guarantor cash negotiated amount per session: _____ (cash only cases)

Credit Card: Type:_____ #_____Exp._____Code_____

A $200 payment (equivalent to value of first session rate) *may be required as a deposit to be applied to your balance. CC, check or cash.**

I hereby authorize the release of all medical information necessary to process an insurance claim. I hereby authorize my insurance carrier to make payments directly to Bridget Fanning-Ono. I understand that I am financially responsible for all charges, regardless of insurance, unless otherwise written by Bridget Fanning-Ono . I understand the financial policy established by Bridget Fanning-Ono. I understand that balances left unpaid over 90 days from the date of service may be assessed a 1.5% rebilling / past due account fee (minimum $5.00) per month and / or may be referred to a collection agency to facilitate payment.

_____ Date: _____

Financially Responsible Person (Guarantor) - If other than patient.

Name: _____ DOB: _____

Gender: M F Relation to Patient: _____ SSN: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cellular: _____ Email: _____

May messages be left for you at home? _____At work? _____ Cell? _____ Email? _____

I hereby accept full financial responsibility for the patient outlined on this form. I understand that I am financially responsible for all charges, regardless of insurance, unless otherwise written by Bridget Fanning-Ono. I understand the financial policy established by Bridget Fanning-Ono. I understand that balances left unpaid over 90 days from the date of service may be assessed a 1.5% rebilling / past due account fee (minimum $5.00) per month and / or may be referred to a collection agency to facilitate payment.

_____ Date: _____

*Rarely applicable. Only applies if anticipated insurance payment does not come through; It is meant as a safety guard to be utilized as a last resort so as to ensure that payment can be collected.