Financial Information

Self Pay

I do not currently have insurance coverage for mental health services (or do not wish to utilize my benefits) and will assume full responsibility for payment of services received at the time they are rendered.

Credit Card Authorization

Accept my signature below as authorization to bill my _____Visa _____Mastercard

Account # _____

Expiration Date _____ CVV(3digit number on back of card) _____

For Therapeutic services in the amount of $_____ as they occur for the following client(s)

_____

I give permission to Dr. Saponaro to bill my credit card for missed appointments when not cancelled 24 hours in advance.
The authorization will remain in effect until such time as it is revoked in writing. I certify that I am an authorized signer of the account number provided.

_____

Name as it appears on card Signature Date

Insurance Information

Primary Insurance: _____ Type: _____ (HMO, PPO, POS, etc)
Member ID#: _____ Group#: _____
Customer Service #_____
Primary Insured Name: _____ DOB: _____
Relationship to client: _____

Secondary Insurance: _____ Type: _____ (HMO, PPO, POS, etc)
Member ID#: _____ Group#: _____
Customer Service #_____
Insured Name: _____ DOB: _____
Relationship to patient: _____

I hereby attest that I am, at the time of this appointment, an eligible member of the insurance carrier(s) listed above and understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all deductible, co-insurance, and services not covered by insurance

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