the Happy Mind Company

7601 Conroy Windermere Rd.
Suite 203
Orlando, FL 32835

Telephone: 407-704-1461
Fax: 407-704-1501
www.happymindcompany.com

Primary Insurance: _____ Employer: _____

Name of Policy Holder: _____

SS# of Policy Holder: _____ Relationship to Patient: _____

Date of Birth of Policy Holder: _____

Address (if different from patient's address)

Street: _____ City/ST/Zip: _____

***Please present insurance card to receptionist to copy for our records**

Please remember that insurance is considered a possible source of reimbursement for the fees you pay to the Provider and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. ***If the insurance company doesn't pay within 60 days the patient is responsible for any balance.***

Please be advised some insurance companies require preauthorization for mental health benefits. It is the member's responsibility to ensure that preauthorization has been obtained before services are performed. I understand by signing below any claims denied due to a preauthorization requirement will be the full responsibility of the member.

I understand that if my insurer or the company which manages my mental health benefits requires reports from my therapist, these reports will likely include a treatment plan and periodic updates of the treatment plan. The purpose of these reports is to monitor progress, assure quality and to insure appropriate utilization of services. These reports may require verbal and written summaries which include a statement of the problem, history, diagnosis, a formulation of the problem and the dynamics as well as a plan of treatment. If I am a member of a PPO/HMO this may require reporting to my primary care physician.

I hereby authorize payment directly to The Happy Mind Company of any insurance benefits otherwise payable to me and all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans. Any non-assignable benefits are to be made payable jointly to the above named group and myself. I also give the above named group authorization to file any and all claims on my behalf to the insurance commissioner regarding my insurance company.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. ***I understand that I am financially responsible for all charges whether or not paid by said insurance.*** I hereby authorize assignee to release all information necessary to secure payment.

I certify that all information on this page is true. I have read and understand and agree to the above.

Signed: _____ Printed Name: _____

Date: _____

Responsible Party Signature (if different from patient): _____

Printed Name of Responsible Party: _____ Date: _____