Fara Murata LCSW
RAPHA COUNSELING CENTER
Office: 720-898-4800 Fax: 720-898-5169
www.raphacc.com

Financial Information Form

I truly appreciate your choosing to come to me for psychological help. As part of providing high-quality services, I need to be clear about our financial arrangements. Credit card, check, or cash are acceptable forms of payment. An invoice can provided for you to submit to your insurance, however you are responsible for payment in full.

A. Patient/Child's name: _____ Birthdate: _____

Soc. Sec. #: _____ Home Phone: _____

Cell phone: _____ Address/City/State/Zip: _____

_____

(If the patient is a dependent) Insured's/policy holder's name: _____

Occupation: _____ Employer: _____

Work phone: _____ Address of

Employer:_____

B. (If applicable) Spouse's/Parent's name: _____Birthdate: _____

Soc. Sec. #: _____ Occupation:_____

Employer: _____ Work phone: _____

Address of employer:_____ Cell phone: _____

C. Insurance Information

Subscriber Name:_____Subscriber ID_____ Group # _____

Deductible: $ _____ ❑per person or ❑per family? or ❑per diagnosis?

Co-pay $_____ ❑per fiscal year or ❑per calendar year or ❑per policy year?

How much of this deductible has been used so far? $ _____

Authorization # _____ Limitations: Number of visits: _____ EAP _____

Do you have any other insurance? _____

How will you pay for services from this office? _____

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D. Victims Compensation: Victim's name_____ DOB_____

Police Department involved _____ Social Services involved _____

Case # _____ Date of crime _____

Detective's name _____# _____

Caseworker's name _____#_____

Perpetrator's name _____ Perpetrator's living situation _____

Filled out Victim's Compensation paperwork ___ yes ____ no ____ not sure ____

E. Credit Card Information

Type of Card MC Visa Discover

Card # _____ Date of Expiration _____

Code on back _____ Zip _____

Name on Card _____ Signature _____

I understand that a $5 fee will be added to my credit card charge to cover processing fees.

I understand that a missed appointment fee in the amount of $150 (plus a $5 processing charge) will be charged to this credit card if a 24-hour notice is not given.

I understand that I am responsible for all charges, regardless of insurance coverage.

_____ _____
Client's (or parent/guardian's) signature, indicating agreement to all of the statements above — Date

_____
Printed name

I am willing to communicate via email. I realize that email is not a completely secure way of communication and give Fara Murata, LCSW permission to discuss matters with me in this manner.

Email address: _____

I give Fara Murata, LCSW permission to use my email to send me information. I understand I can unsubscribe at any time. _____ (initials)