Emily Driver Moore, Ph.D.
Clinical Psychologist

2418 Miles SE
Albuquerque, NM 87106

(505) 259-1414
Fax (505) 245-9161

INSURANCE AGREEMENT FORM

In order to provide you with detailed information regarding my services, I request that you review the following agreement and sign in the spaces provided below. If your insurance company requires an original claim form, please provide me with one so that I may receive reimbursement for services provided to you. Thank you for your cooperation.

Initial_____ *All clients are expected to give 24-hour notice for any appointment cancellations. If this is not done, you will be charged full fee. Your insurance policy does not cover missed appointments so these charges will be your responsibility.*

Initial_____ *The client, or named responsible party, is accountable for the entire balance due for services. While I have contracted with your carrier to provide you with services for a discounted fee, if your insurance policy is terminated and I am not notified, any charges accrued that are not cover able by your carrier will be payable by you.*

Initial_____ *If you have a deductible amount which has not yet been met, you will owe payments to me at the time of each session, and your carrier will be billed until your deductible is satisfied, at which time you may resume making co-payments.*

Initial_____ *The client or responsible party is responsible for charges which the insurance carrier does not pay.*

Initial_____ *In the event of an overpayment, a refund will be sent to the authorized party.*

Primary Insurance Company:_____Phone #_____

Address:_____City_____State_____Zip_____

Policy Holder/Employee_____SS# or ID#_____Group#_____

Division and/or Member #_____

Patient's, Insured's, or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the undersigned psychologist for services described below.

Signed:_____ Date_____

Payment Arrangements: Fee: $_____plus tax per therapeutic hour

_____Client to pay in full at each session and to be given a superbill to file his/her own insurance claims for reimbursement

_____Client will pay deductible and/or co-payment at each session, and I will file the insurance claim(s) for reimbursement

_____ _____
Signature of Client or Responsible Party *Date*

_____ _____
Emily Driver Moore, Ph.D. *Date*