

Cruz Clinic
17177 N. Laurel Park Drive Suite 131
Livonia MI 48152
734-462-3210 (ph) 734-462-1024 (fax)

PAYMENT INFORMATION SHEET

Date _____

Patient Name _____ DOB _____

On _____ (Date) _____ (name of staff member at Cruz Clinic) contacted your insurance carrier _____ at _____ (telephone number of insurance carrier) and spoke with _____ (name of person working providing insurance benefit information).

We were advised that your coverage for out-patient mental health services is as follows:

Deductible _____ Co-Pay _____
Maximum visits per calendar year _____ Maximum Visits Lifetime _____
Authorization needed? ___yes ___no If yes, after _____ (number of visits)
If yes, who is required to get this authorization? _____

Based on these benefits your insurance should pay _____

However, please be advised that this is not a guarantee of payment from the insurance company. Also, please be aware that your contract is between you and your insurance provider and therefore we cannot guarantee this information is accurate. Please contact your human resource director or insurance company information packet for more details.

Patient Name

Signature of Responsible Party

Date

Printed Name of Responsible Party

Cruz Clinic Witness

_____ (Please read and initial) I understand that it is my responsibility to know my insurance policy benefits. I realize that Cruz Clinic has contacted my insurance company to receive my benefit information, and I understand that occasionally insurance companies do not provide accurate information. Therefore, I know it is in my best interest to contact my insurance company myself to verify this information. If Cruz Clinic was quoted incorrect information, resulting in lesser benefit coverage, I understand that I am responsible for the difference.

Please advise if you would like us to bill your insurance for services rendered.

_____ (Please initial) Yes, please bill my insurance provider for services rendered

_____ (Please initial) No, I prefer to pay cash for these services