HENRYETTA BERGSTRESSER, LCSW

CLIENT INFORMATION AND PAYMENT AGREEMENT

Is the client a dependent minor or a person of any age under guardianship? Yes ☐ No ☐

ABOUT YOU

NAME: ______________________ ______________ ____/____/____
Legal Name | Name you prefer I use | Date of Birth

RESIDENTIAL ADDRESS: ______________________
Street | Unit | City | State | Zip

MAILING ADDRESS: ______________________
Street or PO Box | Unit | City | State | Zip

PHONE:
( ) Cell # Text/voice message OK? Y ☐ N ☐
( ) Home # Text/voice message OK? Y ☐ N ☐
( ) Work # Text/voice message OK? Y ☐ N ☐

EMAIL:
Primary May we use this email address? Y ☐ N ☐
Secondary May we use this email address? Y ☐ N ☐

EMERGENCY CONTACT: ______________________
Name | Phone #(s) | Relationship

MEDICAL: ______________________
Primary Care Physician | Office Location | Phone #(s)

Psychiatrist or Psychologist | Office Location | Phone #(s)

OTHER: ______________________
Marital Status* | Gender* | Race or Ethnic Origin*

Employment status* | Cultural or religious considerations we should know about*

M: ☐ F: ☐
Sex (Required for insurance) | How did you find us?

Questions marked with an asterisk (*) are optional but can be helpful information for your therapist.

If you are the parent of a minor (17 and under) who is the client, *or* the court-appointed guardian or representative of the client, *or* you will be financially responsible for "private pay" sessions, we will need a form for the client and one for the representative / financially responsible. You do not need to include the "medical", "other", or "insurance" portions unless you are a client yourself.

INSURANCE

You must provide a legible photocopy or photograph of both sides of your insurance card(s). You may e-mail them to Richard@OutOfTheBramble.com or text photos to (707) 407-6971.

If required by your insurer you must obtain preauthorization before your first visit. If you do not obtain preauthorization or if your insurance carrier determines that our services are not covered under their policy you will be responsible for the full payment of all accrued fees. Behavioral health benefits may differ from other benefits, so it is essential that you understand them.

Although your insurance company may cover some or all your fees, ultimately all costs for services are your responsibility.

PRIMARY INSURANCE:

________	________	________
Insurance Company Name	Member ID #	Plan ID #
Address for Claims	Group ID #	Insurance Phone #
Policy Holder's Name (if not you)	Policy Holders Phone #	Policy Holders Date of Birth
Policy Holder's Address *on file with Insurance Co.*	Policy Holder's Employer/School	
Policy Holder's Relationship to You	Policy Holders Sex	Co-Pay / Co-Insurance

SECONDARY INSURANCE:

________	________	________
Insurance Company Name	Member ID #	Plan ID #
Address for Claims	Group ID #	Insurance Phone #
Policy Holder's Name (if not you)	Policy Holders Phone #	Policy Holders Date of Birth
Policy Holder's Address *on file with Insurance Co.*	Policy Holder's Employer/School	
Policy Holder's Relationship to You	Policy Holders Sex	Co-Pay / Co-Insurance

EAP:

________	( ) ________	________	________
Name of EAP	EAP Phone #	Authorization #	# of Sessions Authorized

OTHER IMPORTANT INFORMATION

We are committed to conserving resources – please consider paperless options when available.

STATEMENTS & INVOICES:	Invoices are sent the evening after each appointment. Account statements are sent on the 1st of each month, and "superbills" for insurance reimbursement on the 10th of each month. All clients will receive these via email and can access them through the web portal.
REMINDERS:	Appointment reminders are sent to all clients via text 24 hours before your appointment unless you specifically request not to receive them. If you prefer reminders by voice message or email let us know.
WEB ACCESS:	All clients receive access to the web portal, a secure, HIPAA-compliant way to interact with us. Through the portal you may view your invoices and statements, make a payment via credit card, upload or download documents, and access your secure video sessions.
PAYMENT:	For payment we accept cash, checks, and credit cards. Payment is due at the time of service. If you use the web portal you may securely enter your credit card information there – we will not have access to your full credit card information.
AUTOPAY:	You may enroll in autopay through the web portal. The credit card you entered will automatically be billed the night after your appointment. Because it's easy and consistent we encourage this method of payment.

COMMUNICATION

CONSENT: By checking "Yes" in the box to the right I consent to allow Henryetta Bergstresser, LCSW, or her designee(s) to communicate with me regarding my protected health information and/or personally identifiable information using text messaging and/or email, using the phone number and/or email I have provided. I understand that Henryetta Bergstresser, LCSW, is not responsible for the security of text messages and/or email sent to and from me. I may opt out of text and/or email messaging in writing at any time and understand that it is my responsibility to advise if any information changes.

☐ Yes

☐ No

Agreement

The following agreement is made between the client as signed/submitted below and Henryetta Bergstresser, LCSW, hereafter referred to as the provider:

1) The information I have provided above is true, correct, and complete to the best of my knowledge.
2) I consent to the copying and release of medical records to insurance company(ies) for the sole purpose of the processing of claims related to services provided. I understand that I have the right to inspect the information released through this authorization, that I may revoke this authorization in writing at any time, and that any information released prior to revocation may be used to the purposes stated above. I further understand that a photocopy of this authorization shall have the same force as the original and that, absent other revocation, this release will be valid for one year after my last appointment with the provider.
3) I understand that payment in full is due at the time of service unless other arrangements have been made. I understand that I am ultimately responsible for all fees for services, including those rejected by my insurance company and for which the provider has received no payment.
4) I understand that for services covered by an insurance carrier whom the provider *can* directly bill the payment for any additional co-pay, fees, or other services not covered by the insurer are due at the time of service. I understand that for services that may be covered by an insurer that the provider *cannot* directly bill payment in full is due at the time of service and a “super bill” will be provided to the client to present to their insurance carrier for reimbursement.
5) I understand that if my account has not been paid for more than sixty (60) days and no other arrangements have been made between the provider and myself that the provider may use any legal means to secure payment. This may include the hiring of a debt collection agency. If such legal action is necessary the cost of that action, in addition to the amount past due, will be my responsibility.
6) I assign Henryetta Bergstresser, LCSW the right to any claim or reimbursement for services she/they have provided.

Client:

Signature ______________________ Date __________

Name (Please Print) ______________________ Date of Birth __________

Spouse or partner of client (if involved in therapy sessions):

Signature ______________________ Date __________

Name (Please Print) ______________________ Date of Birth __________

Parent of minor or court-appointed guardian or representative of client:

Signature ______________________ Date __________

Name (Please Print) ______________________ Date of Birth __________