STEVEN REISLER, PSY.D.
FINANCIAL FORM

CLIENT NAME _____ **MARITAL STATUS** _____

DATE OF BIRTH _____ **MALE** ____ **FEMALE** ____ **SS#**_____

LOCATION: **PRIVATE PRACTICE**

PRIMARY INSURANCE _____
NAME OF COMPANY

_____
POLICY NUMBER (INCLUDING SUFFIX)

SECONDARY INSURANCE _____
NAME OF COMPANY (IF BC/BS - WHICH STATE)

_____
POLICY NUMBER

PROVIDER OF SERVICES ACCEPTS ASSIGNMENT. THE CLIENT WILL BE RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

CLIENT UNDERSTANDS HIS/HER RESPONSIBILITY: ☐ **YES** ☐ **NO**

COMMENTS: __PATIENT UNDERSTANDS THAT THEY ARE RESPONSIBLE FOR ANY CO-PAYMENT FEES. PATIENT FURTHER UNDERSTANDS THAT IF THERE IS A NEED TO CANCEL WITHOUT 24 HOUR PRIOR NOTIFICATION, PATIENT WILL BE RESPONSIBLE FOR THE COST OF THE SESSION.

CO-PAY FOR SESSIONS ($_____)_____

_____ _____
CLINICIAN SIGNATURE **DATE**

_____
CLIENT SIGNATURE