

**Arrowhead Psychological & Behavioral Sciences, LLC**  
**1501 14<sup>th</sup> Street West Ste. 230 Billings, MT 59102 406-294-9510**

**Therapy Fee/Insurance Agreement**

Client Name: \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Phone: Work \_\_\_\_\_ Home \_\_\_\_\_  
Parent/Guardian Name: \_\_\_\_\_  
Address (if different than above) \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Work Phone #: \_\_\_\_\_ Home Phone #: \_\_\_\_\_  
Emergency Name and Number: \_\_\_\_\_

**If you have insurance, please fill out the following:**

Name of Insurance Company: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_  
Group or Policy Number: \_\_\_\_\_ Insured's ID Number: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
Work phone #: \_\_\_\_\_ Home phone #: \_\_\_\_\_  
Insured's DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

**Are you a recipient of Medicaid or Medicare services?**

Medicaid Number \_\_\_\_\_ DOB: \_\_\_\_\_  
Medicare Company and Number: \_\_\_\_\_

**The Fee for Therapy Services is \$100.00 per 50-60 minute session**

Do you have any questions about fees or funding? Yes \_\_\_\_\_ No \_\_\_\_\_

- Appointments must be canceled 24 hours in advance to guarantee there will be no charge.
- Failure to cancel or show for appointments will result in a \$100.00 charge.
- In the event that your account goes to collections, there will be a 30% collection fee added to your balance.

**Please sign and date:** \_\_\_\_\_

**I herby authorize my insurance company to pay directly to:** Arrowhead Psychological & Behavioral Sciences, LLC at 1501 14<sup>th</sup> Street West Ste 230 Billings, Montana 59102

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**INTERNAL USE ONLY: First Date Seen:** \_\_\_\_\_ **Diagnosis:** \_\_\_\_\_