LINDA EVANS PH.D.
TOWN CENTER, 116 W. 7TH, SUITE 211
STILLWATER, OK 74074
405-707-9600

INSURED'S NAME_____AGE_____
ADDRESS_____
HOME PHONE_____WORK PHONE_____
CELL PHONE_____SS#_____DOB_____
EMAIL_____
EMPLOYER_____ADDRESS_____
INSURANCE CO._____
POLICY#_____GROUP#_____
INSURANCE CO. ADDRESS_____
ID#_____**PATIENT'S NAME**_____
INSURED'S RELATIONSHIP TO PATIENT _____
INSURANCE CO. PHONE NUMBERS _____
_____
SUPPLEMENTAL INSURANCE?_____POLICY # & COMPANY_____
_____

Agreement

I agree to be financially responsible for the charges incurred in counseling the above named patient. Under circumstances that Dr. Ferguson is billing my family member's insurance company; I understand that insurance is billed as a courtesy to the patient and that the financially responsible party is ultimately responsible for all counseling fees. I also understand that unless Dr. Evans is "in network" on patient's insurance, that I am responsible for payment at the time of the sessions. In this case, after my deductible has been met, I would be responsible for paying the copay at the time of each session. Until my deductible is met, I am responsible for full payment of each session at the time of the session. I understand that insurance is billed once per claim and that I am responsible for any subsequent communication with the insurance company (and its representatives, including any Employee Assistance Program personnel) and any problem solving necessary. I agree to release to the insurance company any information necessary for payment.

I agree to release the above named insurance company and its representatives to make payment directly to Dr. Evans for counseling services.

I further understand that Dr. Evans charges $75.00 cancellation fee for appointments that are not cancelled 24 hours in advance of scheduled appointments. I am responsible for this $75.00 fee, which is not billed to or reimbursable by the insurance company.

_____
Signature of Responsible Party

Please attach a copy of the front and back of your insurance card.