SOAR SERVICES, Inc.

Offices in: Shell Lake, Siren, Hayward, Ashland, Park Falls and Superior

246 Industrial Blvd.,
PO Box 265,
Shell Lake, Wisconsin 54871
Phone; (715) 468-2841
Fax: (715) 468-2374

NAME: _____ DOB: _____

PHONE/CELL: _____ SEX: M F

REMINDER TEXT _____OR CALL _____

EMAIL ADDRESS: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER & PHONE # _____

REFERRAL SOURCE: _____

GUARDIAN NAME AND #: _____

SELF PAY: Fee Agreement

The patient fee is $_____ per session. I hereby agree to this fee and ensure prompt payment of this upon each visit, according to these arrangements made with my therapist (_____). I understand I am responsible for all fees incurred, whether or not insurance covers the cost in part or in full determines services are not medically necessary and denies payment. Insurance information presented above is an estimate and not a guarantee of insurance payment.

Assignment of Insurance Benefits

I request that payment of authorized insurance benefits be made on my behalf to Soar Services Inc. for any services furnished me by the providers of that facility. I authorize any holder of hospital or medical information about me to be released to the Health Care Financing Administration and its agent needed to determine the benefits payable for related services.

I hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further agree and acknowledge that my signature on this document authorizes Soar Services to submit claims for benefits, for services rendered or for myself and/or my dependents, and that I will be bound by this signature as though I had personally signed this particular form. I HEREBY ASSIGN DIRECTLY TO SOAR SERVICES IN, ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED.

COPY OF INSURANCE CARD NEEDED! COPY OF INSURANCE CARE NEEDED!

Signature: _____
Date: _____

Billing diagnosis F: _____