

YOUR COVERAGE: When you use your health insurance plan to pay for mental health services, you agree to work with your insurance company to ensure that payment is made in full. You are responsible for understanding the details of your insurance coverage, including the amount of your deductible, the total number of sessions you are allowed, and the amount of your copay. You are responsible for providing me with the information necessary to bill your insurance provider, including your complete insurance identification information and group number.

PRIOR AUTHORIZATION: Some insurance plans require that you obtain prior authorization (also called pre-authorization) for mental health services before seeing a mental health provider. When required, it is your responsibility to obtain prior authorization from your insurance company for services before any sessions are held. You are responsible for payment in full for all services not reimbursed by your insurance company.

CLINICAL DIAGNOSIS: Insurance companies require that I provide a DMS-5 diagnosis. A diagnosis is required because insurance companies will only provide coverage for services that they deem to be medically necessary. Any diagnosis becomes part of your medical history.

CONFIDENTIAL INFORMATION: Your insurance company may require that I share treatment plans, progress reports and, in some cases, session notes, regarding your treatment. Although insurance companies are required to keep your information confidential, I have no control over your information once it is sent to your insurance company.

PAYMENT: When I agree to accept insurance as payment for my services, I am agreeing to a reduced fee for services, since insurance companies set their own rates for services. Your copay only pays a portion of this reduced rate.

DENIED PAYMENTS: If your insurance company denies payment due to an error made by this office, I will work to correct the error and will resubmit your claim. If your insurance company denies payment for other reasons, you are responsible to either work to correct the error or for payment in full for all services not reimbursed by your insurance company.

MISSED AND LATE-CANCELED APPOINTMENTS: Insurance companies do not reimburse for appointments you miss or for appointments that you cancel late (with less than 24 hours' notice). You are responsible for paying the full session fee for appointments missed or cancelled late. This fee will be automatically charged to your credit card on file.

OUT-OF-NETWORK REIMBURSEMENT: If I am not a provider under your insurance plan, and you would like to seek out-of-network reimbursement, I will provide you with an invoice that you can submit to your insurance company. You are responsible for paying the agreed amount at the time of service.

I, _____ [CLIENT NAME], **have read and understand the information and policies set forth above and agree to the terms and conditions stated in this document.**

Client signature ►

Date ►

Please complete the insurance information form on the following page.

Insurance Information Form

Client information

Client's name (First, MI, Last) ▼	Client's birth date ▼ / /
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Insurance company information

Insurance Company name ▼	Member ID ▼	Group Number ▼
Effective date (month/day/year) ▼ / /	Provider phone number ▼ <small>(THIS IS TYPICALLY A TOLL-FREE NUMBER LOCATED ON THE BACK OF YOUR INSURANCE CARD.)</small>	

Insured's information

Insured's name (First, MI, Last) ▼	Birth date (month/day/year) ▼ / /			
Client's relationship to the Insured ▼ <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other (specify):				
Insured's address (number and street) ▼	Apt. no. ▼	City/town ▼	State ▼	Zip ▼
Insured's phone number ▼	Insured's employer ▼			