

HEALTH INSURANCE INFORMATION

Dear Client, we look forward to seeing you and we will gladly file your sessions with the counselor to your insurance company, however, we do not verify coverage or call to get the information concerning your coverage for you. You must **call** the phone number(s) on your health insurance card to get the following information **PRIOR** to your first session.

Without ALL questions on this form answered by your Insurance Company you will be responsible for the full session fee.

Name: _____ Date of Birth: _____

Insured's Name: _____ SS #: _____

Name of Insurance Company: _____ Effective date: _____

Insured's ID number _____ Group Numbers: _____

You MUST call the number on your insurance card and ASK THESE QUESTIONS:

****VERY IMPORTANT** to what address do we mail Mental Health Claims?**

Do I have **mental** out-patient benefits? Yes _____ No _____ (if not stop)

Is (give counselors name) on my provider list? Yes _____ No _____

If not, do I have any "**out of network**" benefits? Yes _____ No _____
(Write what those benefits are on the back of this form)

Do I have a deductible? Yes _____ No _____

If applicable, how much of that deductible have I met? N/A _____ or \$ _____

What is my co-payment for **mental health**? \$ _____ per session

How many sessions are allowed per calendar year? _____

(If applicable) do I have marital counseling benefits? Yes _____ No _____

Is prior authorization needed for counseling? Yes _____ No _____ (if not stop)

Authorization number? _____ how many sessions are authorized? _____

For what dates are those sessions authorized? From: _____ To: _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process claims.

SIGNED: _____ **DATE:** _____

INSURED'S OR AUTHORIZED PERON'S SIGNATURE I authorize payment of medical benefits to the counselor who provided the service.

SIGNED: _____ **DATE:** _____