Use of Insurance

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Providers (therapists) who participate in insurer contracts (e.g. accept insurance like Blue Cross Blue Shield, United, etc.) are obligated to verify client insurance status prior to providing services. You have the right to opt not to use your insurance coverage for any reason; however, you are required to formally document your decision.

Client Name: _____ Date of Birth: _____

By signing below *(select one (1) of the four (4) applicable agreements)*, I attest that I understand and agree to the following regarding my insurance coverage and I agree to immediately notify my provider of any changes to my insurance status in the future.

1) **I have insurance and intend to use it.** I hereby authorize the release of all information necessary to secure payments from my insurance company. For in-network services I assign payments directly to my provider; for out-of-network services I will receive payments directly from my insurer if applicable. I understand my insurer will only estimate my benefits in advance of services and will not guarantee the estimate until after claims are processed.

I understand that I am financially responsible for payments if my insurer denies a claim for any reason. Reasons claims may be denied include if my deductible is not met, if my benefits change in new term periods, if I exceed the number of allowed sessions in a term, or if medical necessity for treatment is denied.

Signed: _____ Date: _____
Insurance Company: _____
Plan: _____

Provider Services Phone Number: _____
Claims Address or Payer ID: _____

ID#: _____ Group#: _____
Name of Insured: _____
□ Myself □ Spouse □ Parent □ Other

Insured's Date of Birth: _____ Insured's Employer: _____
Insured's Address: _____
Insured's Phone Number: _____

2) **This provider is classified as IN-NETWORK on my current insurance plan and I DO NOT wish to use it, or am aware services are NOT COVERED by my policy.** I will pay my insurer's total allowable charge for services and waive rights to reimbursement. I cannot request retroactive billing to my insurance if I change my mind in the future.

Signed: _____ Date: _____

3) **This provider is classified as OUT-OF-NETWORK on my current insurance plan and I do not want to file out-of-network claims.** I cannot request retroactive billing to my insurance if I change my mind in the future.

Signed: _____ Date: _____

4) **I do not have insurance.** I understand I am responsible for my provider's self-pay rates as set in my payment policy.

Signed: _____ Date: _____

Please note that all no-shows will be paid through the credit card on file and clients will be charged the full rate that their insurance reimburses or the full rate that is agreed upon for private pay clients. This amount will not be reimbursable through a client's insurance. A no-show is defined as a cancellation prior to 24 hours prior to your scheduled appointment. This is standard practice as appointments are your time that is reserved for you.