INSURANCE AGREEMENT

Your Name: _____
Your Address: _____
Your Phone Number: _____ Date of Birth: _____

Name of Insurance Company:_____
Contract or ID #:_____ Group #_____
Name of Policyholder:_____
Policyholder's date of birth:_____ Relationship to client:_____
Employer of policyholder:_____

Provider Phone Number (see back of insurance card):_____

If my insurance program covers services, I understand that:

- My insurance carrier may require me to call them for authorized coverage of my first appointment. If this authorization is not obtained, I understand that I am responsible for full payment of the appointment fee.
- Each counseling appointment counts as one visit towards the total number of visits allowed under my insurance coverage.
- My insurance company may set a limit on how many visits I have for psychotherapy in a calendar year.
- My insurance carrier may provide coverage only to the extent that they deem **"medically necessary".**
- I am responsible for any insurance deductibles required by my insurance company and must pay full fee each time I am seen until the deductible is met.
- I am responsible for any portion not covered by my insurance.
- I am responsible for informing my therapist of any change in insurance coverage prior to the date the coverage begins.
- I am responsible for being aware of my insurance policy's coverage of pre-existing conditions.

RELEASE OF INFORMATION

I authorize therapist to release medical or other information necessary to process my insurance claim.
I request payment of government and/or insurance benefits made to therapist for services rendered.

- I authorize my primary insurance to provide information as necessary to my secondary insurance company to facilitate the coordination of my benefits necessary to process my insurance.

Client Signature:_____ Date: _____

Parent/Guardian Signature:_____ Date: _____