Desert Streams Christian Counseling

INSURANCE INFORMATION FORM

Client Name _____ **Date** _____

It is your responsibility to contact your insurance company prior to your first appointment to verify your benefits. We do not verify benefits.

Please keep in mind that deductibles and co-pays for mental health services are often different than for other medical services. Please contact your insurance company prior to your first appointment. Generally, a phone number is listed on the back of your insurance card to call to verify your benefits.

If your counselor is an LLPC, LLMSW or LLP: ***Billing may be done under a supervisor for your insurance.*** Please contact your insurance carrier to inquire whether billing under a supervisor is allowed under your plan, not all plans have this provision.

Please come to your first appointment with the following information about your insurance:

1. Does your insurance have out patient mental health benefits? Yes No
2. Does your insurance require you to see a network provider? Yes No
   If yes, is your therapist a network provider? Yes No
   If no, do you have out-of-network benefits to cover services? Yes No
3. Are there any restrictions on the license of the service provider? Yes No
   If yes, will it cover: LP MSW LLP LPC LMFT
   If yes, will it cover the following providers with supervision: LLMSW LLP LLPC LLMFT
4. Does your insurance plan require authorization/pre-certification? Yes No
   If authorization/pre-certification is required, what is the phone number to call?
   Phone # _____
5. Does your plan have deductibles? Yes No
   If yes, what is the amount of the deductibles? _____
   Have you met your deductibles? Yes No
6. Amount of your co-pay or payment responsibility per session? _____
7. Does your insurance have visit limits? If so, how many visits? _____

Please be prepared to make a payment, for the first appointment if you are unable to supply us with the needed insurance information as outlined above. If you are paying out of pocket vs billing insurance, payment is expected at each visit.

I understand that it is my responsibility to verify insurance coverage and that I will be financially responsible for anything my insurance provider does not cover.

Signature: _____ **Date:** _____

Thank you for your cooperation. Please feel free to contact our office at 345-0909 if you have any questions. If special financial consideration is required please discuss this with your therapist.