INSURANCE VERIFICATION NOTICE

(Not applicable to Medicaid clients.)

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.

Client Name: _____

Signature: _____ Date: _____

Please feel free to contact our office if you have any questions.

If special financial consideration is needed, please discuss this with your therapist.

If you would like to know what your insurance covers prior to your appointment:

1. Call the Customer Service number on the back of your insurance card and ask for your **Outpatient Mental Health** coverage.
2. Is Desert Streams Christian Counseling and your specific therapist in network?
3. Does your plan require authorization or precertification? Yes / No

   If yes, what is the phone number to call? _____
4. Does your Deductible apply? Yes / No

   If yes, Deductible Total: _____ Deductible amount paid so far: _____
5. Coinsurance / Copay: _____