MIND MATTERS
MENTAL HEALTH & WELLNESS

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Insurance Verification / Payment for Services

Name: _____ DOB:_____

SS#_____ **Male / Female** Marital Status **M S D W**

Address: _____ City:_____ State:_____ Zip**:**_____

Phone (H) _____ (Cell) _____ Parent(s) _____

Ok to call? Y / N Text Y / N Email: _____

Reason for visit: _____ DX: _____

Previously Involved in Counseling **Y / N** Information for Therapist _____

Primary Insurance

Insurance Company: _____

Subscriber Name: _____ **Male / Female**

Subscriber DOB: _____ Relationship: Self / Spouse / Child

ID# on card: _____

Group#:_____Employer: _____

Benefits Phone: _____

*If secondary insurance is applicable, please write the same information on the back of this form

(This section filled out by Therapist)

Name of Rep: _____ Date: _____

Effective Date: _____ Benefit Year: _____ Out of Network Benefits? Y N

Deductible: (I) _____ (F) _____

Deductible Met? (Individual)_____Family_____

Co-pay: _____ Co-Ins: _____Co Ins Max_____

Other: _____Visit Limits_____

Authorization Required: **Yes No **Auth. for 90837: **Yes No**

Are there any excluded mental health benefits? (Family Sessions?) **Yes No

Address for Claims: _____

Deductible/Coinsurance/Copay Amounts to Collect:
(filled out by Therapist)

	Deductible	/	Co Ins/Pay
	_____		_____
90791	_____	/	_____
90832	_____	/	_____
90834	_____	/	_____
90837	_____	/	_____
90847	_____	/	_____
90849	_____	/	_____
90785	_____	/	_____

Active Yes / No _____

**** If opting for Private Pay, please initial HERE** _____ / _____ provider initials in agreement

Individual Session (45 minutes) $_____ (60 minutes) $_____

Family/Couples Session (45-60 minutes) $_____

*I understand that having insurance coverage does not guarantee payment for therapeutic services and that I assume financial responsibility for all changes. My signature below authorizes the insurance company to pay for therapeutic services as a **financial contract**. I understand that my provider reserves the right to collect copayment, at a rate determined by my insurance company, prior to providing services. If I have opted for Private Pay, payment will be made directly to my therapist at the time of services.*

Signature:_____ Date:_____