

**INSURANCE VERIFICATION AND FEE AGREEMENT FORM**

Regardless of your insurance carrier or form of insurance, you are ultimately responsible for payment for services you receive from Eastern Slope Counseling and Consulting (ESCC). Please present a valid identification card and your current insurance card at the time of your first appointment with your counselor.

Complete sections 1 and 2 below. If you have a copayment due, please tell us so that we can collect it at the beginning of your session.

1. **Patient Information**

Patient Name:

Mailing Address:

Home Phone No.: Mobile No.:

Work No.: Ext.:

SSN: DOB: Gender:

1. **Patient Insurance Information**

**Primary Insurance:**

Policy Number: Group Number:

Primary Insurance phone number:

*Subscriber’s Name: DOB:*

Subscriber’s relationship to patient:

**Secondary insurance:**

Policy Number: Group Number:

Secondary Insurance phone number:

Subscriber’s Name:

Subscriber’s relationship to patient:

1. **Patient Eligibility and Benefits Information**

Effective Date of Coverage:

Coverage Terminated? Yes [ ]  No [ ]  Date:

Plan Type: [ ]  HMO [ ]  PPO [ ]  POS Other:

In-Network Benefits:

$ $ Deductible satisfied? Yes [ ]  No [ ]  N/a [ ]

 Co-Payment Deductible

$ $

 Co-Insurance Other Out-of-Pocket Expense

Benefits for Treatment? Yes [ ]  No [ ]

Is a Referral Necessary? Yes [ ]  No [ ]

Is Prior-Authorization Necessary? Yes [ ]  No [ ]

Out-of-Network Benefits? Yes [ ]  No [ ]

Out-of-Network Financial Responsibilities? Yes [ ]  No [ ]

1. **Insurer Information**

Call Date: Time of Call:

Name of Insurance Rep.:

Ph. Number/Ext.:

Prior-Authorization Ph. No.: Fax No.:

Prior-Authorization Contact Name:

Prior-Authorization Approval No.:

Referral Ph. No.: Fax No.:

Referral Contact Name:

Notes:

1. **Self-Pay Fee Agreement**

As client has no insurance, insurance coverage has lapsed, or client has chosen to pay for counseling out of pocket, client agrees to the following fees for ESCC services, payable at the time services are rendered:

Initial Assessment (CPT 90791): $

Individual Psychotherapy (CPT 90837 – 60 minute session): $

Couples Counseling (CPT 90837): $

Family Counseling (CPT 90846 or 90847): $

Group Psychotherapy (CPT 90853): $

**Client Name:**

**Client Signature:** **Date:**

NOTES: