This form is to make YOU aware of what YOUR insurance does not cover and what your financial responsibility is, *if any*. We will also verify your benefits for comparison, so this does not replace the verification we will do ourselves internally in the office.

PATIENT SELF VERIFICATION – INSURANCE BENEFIT COVERAGE

Notice you MUST email to reidwash214@comcast.net your insurance card, valid identification and these completed forms, prior to your appointment. If we do not have a valid insurance card at the time of your appointment you will be responsible for $150.00 per visit until we receive this information.

BEFORE YOU CALL YOUR INSURANCE COMPANY, HAVE READY:

Patient's Name: _____ Date of Birth: _____

Subscriber's Name (spouse/parent): _____ Date of Birth: _____

Insurance Company Name: _____ ID Number: _____

Group Number _____ Your chief complaint: _____
(some insurance companies may ask you this)

WHEN YOU CALL YOUR INSURANCE COMPANY SAY:

I'm calling to verify my insurance for Mental Health/Mental Nervous in an OFFICE "setting"

Telephone Number you called: _____ Person you spoke with _____

If they ask where you are having your therapy: ***Donna Reid Washington, MHS, LPC, Tax identification number is 85-3156126.***

This provider is licensed as a licensed professional counselor. Office is located at 1775 Eye St., NW, Suite 1150, WDC 20006

Obtain answers to the following questions:

1. Effective Date of Coverage: _____
2. Current Deductible, if any $ _____ How much is remaining $ _____
3. Co-Pay $_____ per visit
4. Co-insurance: insurance will pay _____ % and my responsibility is _____%
5. Number of visit's allowed _____ per calendar or contract year *(circle one)*
6. Yearly/lifetime maximum: _____
7. Family and/or marriage counseling is covered? _____ ❒ N/A-I am not coming in for this
8. I have verified that I am seeking services for is a covered benefit? _____
9. Is a referral required? Yes / No *(circle one)* *If yes from where?* _____
10. Is an authorization required? Yes / No *(circle one)* *If yes from where?* _____
    Telephone number to call to obtain authorization _____

If you had to obtain an authorization, what is:

a. Authorization number: _____
b. Start Date _____ End Date _____
c. Number of visits authorized: _____

Address to submit claims: _____

Name of person verifying this coverage:

_____

Patient / Parent-Legal Guardian *(circle one)*

Date: _____