



Health Insurance Information and Consent

Patient's Name _____

Date of Birth _____

Initial Each Section and Sign at the Bottom:

_____ I authorize InPsych Consultants, P.A. to obtain insurance benefits, submit claims, and receive payments of medical and behavioral health benefits on my behalf. I understand that if using my insurance plan, payment by the insurance company cannot be guaranteed. I understand that I am responsible to meet any deductibles and pay any co-payments and/or coinsurance as determined by my benefits. I am responsible for this amount at each scheduled appointment.

_____ If I receive payments directly from my insurance company, I will immediately submit these payments to InPsych Consultants, P.A. In the event that the insurance company misquoted my benefits, my benefits changed, or refuses to make payment, I will be responsible for all unpaid balances. If the carrier reevaluates my benefits even after a payment is made and requests a refund for that amount due to a processing error, an inactive policy, a preexisting condition, or other explanation, I am responsible for making payment to InPsych Consultants, P.A. in the amount of the refund in a prompt manner.

_____ If my policy changes or is terminated, or if I transfer my coverage to another insurance company, I will notify InPsych Consultants, P.A. immediately. I will also provide the new insurance information prior to the scheduled appointment to the business office so benefits can be called in and potential authorization can be obtained. A copy of my new insurance card will also be submitted at the first visit utilizing that coverage.

_____ I understand that many insurance plans may have a certain number of limited therapy sessions per year. That coverage may also require additional authorizations routinely. I understand that the number of visits allotted is for all accrued visits from any behavioral health provider that I see. Should my benefits exhaust, I understand that provider will do his/her best to help my continuity of care and offer me an alternative fee arrangements with us and or link you to a community outreach center.

_____ I understand that at times, disclosure of confidential information may be required by my health insurance carrier or managed care company. Information often requested includes dates/time of services, types of procedures, diagnosis and its manifestations, treatment plans, and progress of therapy. If it is the case that my insurance company utilizes a managed care company, my provider may need to discuss my treatment with a case manager and/or at times dispense case notes and summaries. I understand that my confidentiality may be compromised in such a case. I realize that his/her doing so is a necessity in the efforts to secure ongoing care. If I instruct my provider, he or she will attempt to give only the minimum necessary information in communicating to the carrier. I understand that my provider has no control or knowledge over what insurance companies do with the information submitted or who has access to this information.

Patient's Printed Name

Date of Birth of Patient

Patient/Parent/Guardian's Signature

Date Signed