Dr. Michelle Channing, P.A.

Health Insurance Information and Consent

Patient's Name _____ Date of Birth _____

Initial Each Section and Sign at the Bottom:

_____ I authorize Dr. Michelle Channing, 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 Dr. Michelle Channing, 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 Dr. Michelle Channing, 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 Dr. Michelle Channing, 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

2741 Executive Park Drive, Suite 1
Weston, Florida 33331

www.InPsychConsultants.com
info@InPsychConsultants.com

954-385-6750 Phone
954-385-6757 Fax