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Insurance Plan Reimbursement Agreement Form

Client Legal Name: _____

Primary Policy Holder (if different from Client): _____

Primary Insurance Plan: _____

Your therapist may participate with several insurance plans and documentation may be submitted to your insurance company at no additional cost. Most insurance plans have a deductible and/or session copayment that is your responsibility. Payments of session fees are due at the time of service. Acceptable methods of payment are cash, check, and most major credit cards. You are also responsible for any fees not covered or not paid or denied by your insurance company. Account balances must be paid prior to or at the beginning of the next session. Continuation of services may be dependent on having your account in good standing. Please contact your insurance company to determine your benefits and authorization requirements. If your insurance company requires a pre-authorization, please have the required information with you at the first session. Every effort will be made to verify coverage and identify financial liability (such as deductibles, co-pays, etc.), however, it is ultimately the client's responsibility to know his/her coverage and resolve any non-payment issues directly with the insurance company. Client will also notify therapist immediately in the event that the insurance plan/coverage changes or lapses, and will be responsible for any services not covered as a result of plan changes.

Any overpayment that might occur due to misquoted benefits or deductible completion will be refunded to you or held in your account to pay for future services, if applicable.

Any fees incurred by your therapist from credit card companies, collection agencies or banks due to non-sufficient funds, payment disputes, or non-payment of fees will be passed along to the client.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client) although other persons or insurance companies may make payments on my (or this client's) account.

I hereby assign all mental health benefits, including major benefits to which I am entitled, as well as Medicare and other government-sponsored programs, private insurance, and any other health plan to the designated therapist. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize the designated therapist to release all information necessary to secure payment.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREED TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____	_____	_____
Printed Name of Client (or legal guardian if minor)	**Signature of Client (or legal guardian)**	**Date**
John Cutrone, LMHC, A-CAS	_____	_____
Printed Name of Witness	**Signature of Witness**	**Date**