Finding Freedom Nutrition and Counseling, LLC

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INSURANCE DOCUMENTATION

Due to recent changes in individual policies, clients will be asked to contact their insurance companies to verify services covered under their individual plans. In order to process sessions under insurance, this form will need to be completed with a reference number. If the information has not been completed prior to session, Finding Freedom Nutrition and Counseling, LLC will require full payment up front for services offered. Thank you for your understanding.

Subscribers Name: _____ (First Middle Last) Subscribers DOB:_____ (MM/DD/YYYY) Gender:_____

Patient Name: _____ (First Middle Last) Patient DOB: _____ (MM/DD/YYYY) Gender: _____

Relationship to Subscriber: _____ Patient SSN: _____-_____-_____

Insurance Company: (circle one) United Health Care Other: _____

Insurance Policy #_____ Insurance Group #_____

Provider Services Phone Number: ( )_____

Employers Name:_____ Employers Phone Number: ( ) _____

CONTACT INSURANCE USING THE MEMBER SERVICES NUMBER

You will need to check your benefits under the **Mental/Behavioral Health** portion of your insurance policy.
PLEASE SPECIFY BENEFITS FOR IN-NETWORK VS. OUT-OF-NETWORK PROVIDERS

Ask for the benefits department and provide them with the following information:

Provider name: Finding Freedom Nutrition, LLC/ Aisha Lubinski **Provider NPI:** 148-702-3651

State of Services: Missouri **Service Location:** Outpatient/Office **Service Codes:** 90834 and 90837

Questions to ask: **In-Network Benefits:**

1. Are these services covered under my plan? Yes / No
2. What is the cost of these services to me?
   a. Do I owe a Copay? Yes / No Copay Amount: $_____
   b. Do I owe Co-Insurance? Yes / No Coinsurance: _____%
   c. What is my deductible? $_____
3. Am I limited to a certain number of sessions per year? Yes / No _____ Sessions per year
4. Am I only covered with specific diagnosis? Yes / No
   a. Which diagnosis are covered? _____

If you have insurance other than UnitedHealthCare, please ask about Out-Of-Network:

Questions to ask: **Out-Of-Network Benefits:**

1. Are these services covered under my plan? Yes / No
2. What is the cost of these services to me?
   a. Do I owe a Copay? Yes / No Copay Amount: $_____
   b. Do I owe Co-Insurance? Yes / No Coinsurance: _____%
   c. What is my deductible? $_____
3. Am I limited to a certain number of sessions per year? Yes / No _____ Sessions per year
4. Am I only covered with specific diagnosis? Yes / No
   a. Which diagnosis are covered? _____

When all of this information has been received, please ask for a reference number: _____

Please have a copy of your insurance card ready when you arrive to your appointment

Assignment of Benefits and Authorization to Release Information:

I hereby authorize direct payment of insurance benefits from my insurance company (above) to Aisha Lubinski LPC, RD, LD of Finding Freedom Nutrition, LLC for professional services rendered.

I hereby authorize the release of the above information and any medical information necessary to: 1) provide for adequate coordination of care 2) verify insurance coverage and, 3) to file claims for insurance benefits for professional services rendered.

I HEREBY AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR THAT ARE NOT COVERED BY INSURANCE.

_____

SIGNATURE Date Relationship to patient

*Finding Freedom Nutrition, LLC is only covered under certain policies. If insurance denies claims after submission, you will be responsible for the payment of sessions in full.