Insurance Declaration Form – Self Pay Option - 2023

Submit this document if you intend to pay for services directly.

North Shore Counseling & Emerald Springs Counseling

PO Box 3060, Newport RI 02840
Licensed Telemental Health Services

www.northshorecounseling.com * www.emeraldspringscounseling.com

Choosing to bill for counseling sessions through your insurance carrier is an important decision you must make. According to federal regulations, you may choose to pay out-of-pocket and NOT bill through your insurance policy. Clients who so opt are called, Self-Pay Clients. Should this be your preference, we would NOT have the authorization to share your records with your insurance company. The decision you make at the outset of services may be changed at any time by completing a new form and updating your file. The rates you pay for services as a Self-Pay Client may be higher than the rates you would pay if we were in-network with your insurance company. Should you decide at a later date to bill to your insurance company, your rates for services would reflect either the insurance-rate or Self Pay Client rate at the time services were provided ACCORDING TO YOUR ACTIVE CONTRACT ON THOSE DATES OF SERVICE.

Here is an example. Let's say you opt to be a Self-Pay Client in January and pay for services at $150 per session for 4 weeks. In February, you may sign a new Declaration and authorize billing insurance. Your February sessions will be billed to insurance, but we will not retroactively change your status from Self Pay Client to Insurance Client for those January dates of service. We would provide you (upon your request) with an insurance-ready receipt which you could submit to your insurance company for reimbursement for the January sessions, but the amount you paid above the insurance rate for January would not be refunded to you.

IF IT IS YOUR INTENTION TO PAY DIRECTLY FOR SERVICES AND NOT USE YOUR INSURANCE, THEN PROCEED COMPLETING THIS FORM.

Page 3 of this document is designed to help you communicate with your insurance company about your policy and determine what your out-of-pocket expenses will be. It is not a guarantee of payment. **Because you are opting to be a self-pay client, completing pages 2 and 3 of this form is optional, and the form is offered to you here as a helpful tool should you decide to use it for your own information.**

Knowing your out-of-pocket expenses prior to treatment is your right and your responsibility!

By submitting this form, I opt to be designated as a "Self-Pay Client". I will pay for sessions out-of-pocket with a credit or debit card, in accordance with my signed contract for services. I do not authorize NSC/ESC, its agents or employees, to share my private information with my insurance company.

______________________________ ______________

CLIENT/CLIENT REPRESENTATIVE'S SIGNATURE **DATE**

______________________________ ______________

NORTH SHORE COUNSELING EMPLOYEE/AGENT **DATE**

INSURANCE VERIFICATION DOCUMENT
AS YOU HAVE OPTED TO BE SELF PAY, THIS INFORMATION IS FOR YOUR INFORMATION ONLY.

Policy Holder's Name____ Date of Birth____/_____/__ __ __ __

Address____

Policy ID#____ Policy Group#___________________________

Client's Name: ____Date of Birth____/_____/__ __ __ __

Relationship to Policy Holder ____SELF _____SPOUSE _______PARENT/CHILD

Name of Insurance Company found on the front of the card:____

Any other company names found on the front or back of the card: ____

Phone number for Behavioral/Mental Health____

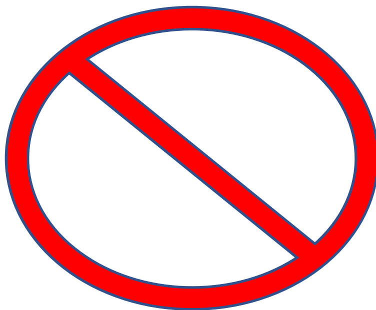
Does your card mention "PRE-AUTHORIZATION" on front or back? YES NO
If YES, what is the phone number listed____

INSURANCE COMPANY'S PAYOR ID (5-digit, can be numbers and/or letters) _____________

Do you have a Health Savings Account you would like to use towards your out of pocket expenses? YES NO
If YES, bring your card with you at the time of service. Be sure you have the funds in your account to pay for services.

WE WILL ONLY BILL DIRECTLY TO COMPANIES WITH WHOM WE ARE IN NETWORK.

We are considered **"OUT OF NETWORK"** with the following companies. We will provide clients with an "INSURANCE READY Receipt when the payment is processed, and payments are due at the time of service:



BEACON HEALTH
BENEFIT PLAN ADMINISTRATORS
HFN
HUMANA
MAGELLAN
MERITAIN
MEDICAID
MEDICARE
HMO PLANS

This is tricky, because you may have United as your insurance, but BEACON for your mental/behavioral health. Use page 3 of this document to figure out your coverage prior to your first appointment.

If your policy is not listed but it is not Aetna, Anthem, BCBS, Cigna, or Optum (formerly United), we are most likely out-of-network. Use the next page to communicate with your insurance company to find out exactly what your out-of-pocket expense will be prior to your first appointment.

Use this page to communicate with your insurance company about coverage for mental health services.
Have your card with you when you call.

Date & Time of call: ______________________________ Name of person who takes your call ______________

Say, "I'm calling to clarify my benefits and coverage for out-patient mental/behavioral health."

The person on the phone will then ask you questions to 'find you' in their system. Be ready to provide the numbers from your card, your date of birth, and your address.

Ask, "Is my therapist, or her group on the Participating Provider List?"

North Shore Counseling, NPI=1073639126, TIN=20-1179777
Emerald Springs Counseling, NPI=1093479743, TIN=87-2384951
Dr. Victoria Manion Fleming, LCPC, NPI=1225115074

YES -- On the Panel ("In Network") _____________ NO -- ("Out of Network")________________

"Can you tell me the benefit information for my provider?" **(clarify IN or OUT of network)**

"What is my deductible?" Amount $ _________ ***"How much has been met to date?"*** Met to date $___________

"Is that for family or individual?"____________ ***"Is it per Calendar Year?"*** Yes/No - Begins_________________

"What is my Copay?" __________________ ***"Is that a fixed amount or percentage?"*** _____________________

"What is the Effective Date of my policy?" _______ ***"How many visits am I allowed per year?"*** _______

"Is Pre-authorization needed?" No/Yes If yes...

"What phone number can my therapist call to preauthorize sessions?" ____________________

"Does my plan cover CPT code 90791__________ 90837____________ 90847 ____________ "

"Are any diagnoses excluded from coverage? __________ Are Z-codes covered?" (e.g., Z63.0)_________"

"What is the company's payor ID?" ___________ "Do you accept electronic submission?" _______________

"How should claims be submitted for either payment to my therapist or reimbursement to me?"

Email_______________________ MAIL____

Other instructions:

____
____
____
____

Verifying benefits does not guarantee payment for services. If preauthorization is required, call your therapist immediately and make sure they know this before your first scheduled appointment!