Insurance Declaration Form - 2023

This document must be acknowledged for us to bill your insurance.

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 UTILIZE YOUR INSURANCE TO PAY FOR SERVICES, 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 intend to utilize insurance to pay for services, we encourage you to complete pages two and three of this document.**

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

By submitting this form, I am asserting that I HAVE COMPLETED PAGE 2 OF THIS DOCUMENT, and I would like to seek payment for services through my insurance company. I understand that if Victoria Fleming is "out of network" with my company or subcontracted insurance vendor/clearing house, I will be responsible for the full rate of services and provided with an "insurance ready" receipt that will contain my diagnosis and other protected information. I accept responsibility for any copays, coinsurance amounts, deductible payments, or any portion of the session fees not covered by my plan. I grant this permission to be effective as of the date of my signature and witnessed by a representative of North Shore Counseling/Emerald Springs Counseling.

_____ _____

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

_____ _____

NORTH SHORE COUNSELING EMPLOYEE/AGENT **DATE**

INSURANCE INFORMATION REQUIRED FOR 3RD PARTY PAYMENT CONSIDERATION.

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_____

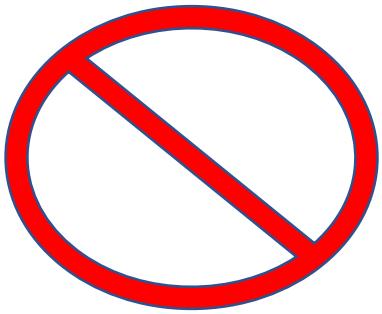
Does your card mention "PRE-AUTHORIZATION" on front or back? YES NO
If YES, what is the phone number listed_____

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 TO_____

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!