



Insurance Reimbursement Information and Release Review and Complete this Form If Insurance Will Be Used

As a service to my clients, I agree to seek reimbursement from your insurance company for our work together. If you would like me to act on your behalf in this manner, I ask that you review this information and sign to acknowledge your agreement that I may disclose information to your insurance company.

To invoice your insurance company, I must disclose to them:

- Your name and dates of service.
- A code indicating the nature of the work (individual, couples or group counseling as appropriate).
- A diagnosis (I will discuss this with you before submitting).
- Though very rarely done, your insurance company will likely have the right to request notes to document our work. I will provide the minimum needed to satisfy their request.

Electronic transmission of records:

Insurance billing is done almost exclusively electronically. I will provide information to a billing service through an internet connection. The insurance company or billing service may communicate through email. Information will be transmitted only by password protected network. My computer will also be password protected, with current anti-virus and firewall software. Backup information will be kept locked up.

Coverage:

I ask that you contact your insurance company to confirm the level of reimbursement, co-pay, and any limits to service (such as limited number of reimbursed visits). For clarity I will also call to confirm the same information. You will be ultimately responsible for payment if the insurance company later refuses payment.

Co-pay:

For those companies that offer a lower reimbursement than my regular fee, or ask for co-payment by you, I ask that you pay the difference between the reimbursement and my fee at the time of service. I will collect the reimbursement directly from the insurance company.

Insurance Plan Information and Agreement:

If you agree to the procedures I've described and would like me to invoice your insurance company for reimbursement, please provide information about your plan on the reverse side of this page and sign the bottom of this form.

Insurance Plan Information:

(If you have an insurance card, you can provide it so I can make a copy rather than completing this form)

Insurance Company: _____

Group or company through which insurance is received: _____

Group number: _____

Policy Number: _____

Insured information, if different than client - Name: _____

Insured's Address _____

Insured's Phone: _____

Insured's Date of Birth: ____ / ____ / ____ Gender _____

Employer Name: _____

Telephone number for coverage questions: _____

Address and phone number for providers (or customer service, if that is what is given):

I agree to have Leland Shields invoice my insurance company for reimbursement and agree to the procedures described above.

Client signature

Date

If insured is different than client:

Insured's signature

Date