Christiane Elsbree, MSW, LICSW
Fees and Insurance

If you wish me to bill your health benefit plan for outpatient mental health services please complete the following:
PLEASE ALSO PROVIDE YOUR HEALTH INSURANCE CARD(S) SO THAT I MAY MAKE A COPY

Subscriber/Insured Name: _____

Subscriber Birth Date: _____ /_____ /_____

Subscriber Address: _____

City:_____ State:_____Zip Code:_____

Patient's Relationship to Subscriber: Self_____ Spouse_____ Child_____ Other_____

Is there another health benefit plan? Yes_____ No_____

If yes, please provide information:

Other Insured's Name: _____

Other Insured's Birth Date: _____ /_____ / _____

Other Insured's Address: _____

City: _____ State: _____Zip Code: _____

Patient's Relationship to Subscriber: Self_____ Spouse_____ Child_____ Other_____

Which Policy is Primary? _____

Agreement to Pay: I understand that I am responsible for payment for all services rendered. Payment at each session is preferred. When I am billed for balances not covered by my health plan, I understand that payment is to be made within thirty days of receipt of statement. **I further understand that I will be charged a late cancellation fee ($100 unless otherwise stated) for all missed appointments not cancelled at least 24 hours in advance. (If cancelling by e-mail please give more than 24 hours notice whenever possible.)** My health benefits plan will not be billed for those appointments.

Signature _____ Date _____ / _____ / _____

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I am happy to submit claims to your health benefits plan. However, you are responsible for payment for all services rendered. Because healthcare plans vary, I recommend that you contact your carrier directly to determine what your costs will be. Here are some questions to ask:

- What is the effective date of your coverage? _____
- Is there coverage for outpatient mental health services? Yes_____ No_____
- Is there an annual deductible that applies to mental health? Yes_____ No_____

  What amount? $_____

  Has it already been met for this year? Yes_____ If not, how much remains? $_____
- Is there an annual out-of-pocket maximum? No_____ Yes_____

  What amount? $_____

  Has it been met for this plan year? Yes_____ If not, how much remains? $_____
- When does your plan year begin? January 1st _____ or other_____
- Is there a required copayment per visit? No_____ If yes, how much? $_____
- Are you required to pay coinsurance (a percentage of the allowed fee)?

  No_____ If yes, how much? _____%
- My NPI # is 1013124817, Am I in-network or out-of network for your plan? IN OUT
- Is there any coverage when seeing an <u>out-of-network</u> provider?

  What is the copayment per visit? $_____

  What is the coinsurance ? _____%
- Are Procedure Codes 90834/90837/90839/90840 covered? Yes_____ No_____
- Are Procedure Codes 90846/90847covered (Family Therapy)? Yes_____ No_____
- Is there a waiting period for preexisting conditions? Yes_____ No_____

  Has it been satisfied? Yes_____ If not when will it end? _____
- Is the number of visits per plan year limited? No_____ If Yes, how many? _____
- Is pre-authorization or referral required for outpatient mental health? Yes_____ No_____

<u>For your information here are the most common CPT (current procedure codes) used and the fees billed to insurance:</u>

90791 Initial Evaluation visit $180
90837 Psychotherapy 60 minutes $150
90785 add-on code for interactive psychotherapy $20
90834 Psychotherapy 45 minutes $120
The flat fee for self-pay clients is $140 per 60-minute visit unless otherwise determined in advance.

The rates allowed vary by carrier. If I am an in-network provider I have agreed to accept the rate set by that insurance carrier and your patient responsibility will be determined by the carrier.

<u>Cost Estimator:</u>
My plan allows $_____for CPT 90837 and $_____for CPT 90785.
My out-of-pocket cost will be _____until my deductible is satisfied and _____after my deductible is satisfied.