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Insurance Disclaimer & Financial Responsibility Agreement

This form outlines important information about your use of insurance benefits for psychotherapy services with this practice. Please read carefully and ask any questions before signing.

1. Verification of Benefits

While the practice may assist in verifying your insurance coverage, it is your responsibility to confirm your mental health benefits with your insurance company. Verification does not guarantee payment or coverage. Coverage is determined solely by your insurance carrier once a claim is processed.

2. Payment Responsibility

You are responsible for any portion of fees not covered or reimbursed by your insurance, including deductibles, copayments, coinsurance, sessions denied or deemed "not medically necessary," sessions beyond plan limits, or missed/late-cancelled appointments. If your insurance recoups or denies payment for any reason, you are responsible for the full session fee, which will be charged to your credit card on file.

3. Coordination of Benefits

You must disclose all active insurance plans at the start of treatment and notify the practice of any changes. Failure to do so may result in denied claims, and you remain responsible for any unpaid balances.

4. Good Faith Estimate

This estimate is a general approximation of your potential out-of-pocket costs for in-network sessions at the start of treatment. Final costs may differ once your insurance processes claims and issues an Explanation of Benefits (EOB). You are encouraged to call the number on the back of your insurance card to confirm your "mental health, outpatient, office visit benefits" and telehealth coverage.

5. Confidentiality & Release for Claims

Submitting insurance claims requires disclosure of limited information, such as diagnosis codes, session dates, and occasionally treatment summaries. By using insurance benefits, you consent to this release of information necessary for claim processing.

6. Assignment of Benefits

By signing below, you authorize payment of insurance benefits directly to this practice and acknowledge responsibility for any portion of fees not paid by your insurance company.

7. Changes to Coverage

You agree to promptly notify the practice of any changes to your insurance coverage or plan type. Failure to do so may result in unpaid balances for which you are responsible.

8. Acknowledgment

I have read, understand, and agree to the above Insurance Disclaimer & Financial Responsibility Agreement.

Client Signature: _____ Date: _____

Partner Signature (if in couples therapy): _____ Date: _____