Insurance Disclaimer

Please be advised that it is **YOUR RESPONSIBILITY:**

1. To give current and correct insurance information.

2. To call your insurance company to verify your outpatient mental health benefits, which includes :

A. Is this provider covered under my policy?
B. Do I need pre-authorization?
C. Do I need deductible?
D. Do I have a co-payment? What is it?
(Deductibles and co-payments are due at time of service)

I hereby understand that any claim denied by my insurance company, due to any of the above Items listed, become my responsibility.

I also understand that if I do not notify this office within 30 days of any insurance policy change, those charges will become my responsibility.

Signature of Responsibility Party: _____ Date: _____

Authorization

To call and Remind Me of My Next appointment

Client Name: _____

1. Call me at this number to leave a message:

Home:_____ Work:_____ Cell:_____

2. Do not call me ___ If you selected #2, please give us a number at which we can reach you in case the office needs to cancel your appointment

Reminder calls are a courtesy and in no way relieves you of the responsibility of keeping your scheduled appointment time. Please remember to cancel appointment 24hours prior to your appointment time. Providers hold the right to charge you for the full amount of your appointment time if not cancelled.

Your Doctor / Nurse Practitioner Name: _____

Signature of Responsible Party: _____ Date: _____

Please Print Name:_____

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