Elisa A.M. Horton, LMFT, LMHC, NCC, Inc.
Fl License Numbers MT 2182, MH 8749

Insurance Information Form

**** Full completion of this form is required for our first session together and will require you to call your health insurance carrier to speak with a representative.** This should only take about 10 minutes of your time but will save you from future stress and unexpected expenses! I will need to see and copy a government issued photo identification card (i.e. a driver's license) and the person seeking service's health insurance card. **

Begin call (number can be found on the back of your insurance card)

1. Date of call: _____/_____/_____ and insurance representative's name &/or ID # that you spoke with: _____
2. "What is the name of company to bill for mental health services?" _____ and "What is their payor ID#?" : _____
3. "Does (the person obtaining service's) plan cover outpatient mental health counseling?" ☐ Yes ☐ No
4. "Does this plan require a referral from my doctor for outpatient mental health?" ☐ Yes ☐ No If yes, "How do I attain a referral?"_____ (Please follow up on attaining the referral prior to your appointment).
5. "Is Elisa Horton, LMFT, LMHC, NCC "in network" on this insurance plan for outpatient mental health services?" ☐ Yes ☐ No (if "no" you will need to ask "what are the out-of-network coverage benefits? Is a separate deductible?", etc – please contact me if this is the case to discuss the details).
6. "Is there an individual or family deductible to be met?" ☐ Yes ☐ No "What is amount left to be met for the individual deductible?" $_____ "What about for the family deductible?" $_____ "Under what circumstance will the family deductible be charged?" _____ "Is this deductible: ☐ per calendar year or ☐ per plan year (between ____/___/___& ____/____/___)?"
5. "What is the copay or co-insurance per session ?" $_____/ _____%
6. "Is there a limit/maximum benefit for this plans outpatient mental health? If so, what is it and how will I know when it is reached?" _____
7. "Is authorization required for outpatient mental health?" ☐ Yes ☐ No If yes, then "What is the authorization code?" #_____
8. "How many sessions does that authorization number entitle the authorized individual to?" _____
9. "What is the date range the authorization is valid through?" ____/____/_____ to ____/____/_____
10. "Will an authorization sheet be mailed, emailed, or faxed to the provider?" ☐ Yes ☐ No

End call

Other questions to be completed:

1) Who is the primary insured on this policy? _____
2) What is his/her DOB? _____
3) Provide his/her address and contact information if different than the client/authorized individual:_____
   _____
4) What is his/her health insurance member ID# _____
5) What is his/her health insurance group policy # _____
6) The employer/who his/her health insurance is through? _____
7) Who is the primary insured in relation to the person seeking services? ☐ self ☐ other relation: _____ (i.e. mother, father, step-mother, guardian, etc)

Authorization to utilize health insurance benefits

I, _____(name of insured or authorized representative), hereby authorize _____(name of behavioral health/mental health insurance carrier being billed) to pay and hereby assign directly to Elisa Horton, LMFT, LMHC, NCC, Inc. all benefits, if any, otherwise payable to this practice for counseling services as described on the attached forms. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Elisa Horton, LMFT, LMHC, NCC, Inc. will be credited to my account, in accordance with above said assignment.

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my therapist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

_____ Date: _____

Authorized Signature of Subscriber

**** If there is a secondary insurance to be billed, please notify me. Also, please print out another one of these forms and follow the same instructions with the secondary insurance. ****