PRACTICAL THERAPEUTIC SOLUTIONS, PLLC
10379-B DEMOCRACY LANE, FAIRFAX, VA 22030
TELE: 703.801.5527 FAX: 703.591.2563

# Insurance Benefits Verification Form (please print clearly)

**Do you have more than one insurance policy for health care? Yes No**
If you have a secondary insurance.

I only submit for the insurance of which I am in-network whether secondary or primary.
If it is secondary, I need a EOB from your submission to be paid for the co-pay within 1 month from service for submission. We will calculate the amount owed per policy.

**Client's Name**: _____

Client's Date of Birth: _____-____-_____

Client's Soc. Sec. No: _____-____-_____ (Tricare only)

Client's Address: _____

**Policy Holder's Name** (if different from client): _____

Policy Holder's Date of Birth: _____-____-_____

Policy Holder's Soc. Sec. #: _____-____-_____ (Tricare only)

Policy Holder's Address: _____

Primary Insurance /Behavioral Health Insurance Plan: _____
Note: This may be different from your medical health insurance plan

Member ID No: _____ Group No: _____

**Questions for Your Insurance Provider**
1) "Do I have mental/behavioral health coverage?" YES NO
If YES, Continue.
If NO, Please contact the therapist with whom you want to work to discuss payment options.

2) "Is my preferred therapist Johnny Powell, LCSW In-Network?" YES NO

3) "Do I have Out-of-Network benefits?" YES NO

If NO for #2 and #3.
Please contact PTS at 703.801.5527 to discuss payments options.

**In-Network Benefits**
4) "What is my co-pay amount?" $_____

5) "Do I have a deductible?" YES NO
If YES, "What is my deductible?" $_____

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**Out-of-Network Benefits**
7) "How much will I be reimbursed if I see an Out-of-Network therapist?" $_____

8) "Do I have an Out-of-Network deductible?". YES NO
If YES "What is my out-of-network deductible?" $_____

**Services Covered**
9) "Please verify that the following services are covered under my policy?"

Individual Therapy YES NO
Couples/Family Therapy YES NO
Group Therapy YES NO
**Services Authorized**

10) "Do I need an authorization to receive any of these services?" YES NO
If YES, "What is my authorization number?" _____
How many sessions are authorized?" _____
For what timeframe? _____

I understand that by signing this form that I have verified this information with my insurance company.

While some treatment I desire is covered by my insurance plan, some is not, and I am willing to pay for the non-covered treatment (ex. Extended sessions, phone or administration requests)

Extended sessions: I am aware that my therapist is able to bill my insurance plan for only 45 or 60 minute sessions per day. IF I desire additional time, I understand that it will be my responsibility to pay for the copayment or deductibles for this session PLUS the cost for any additional time I desire. Additional time will not be billed to the insurance plan. IF the therapist is not a provider for my plan, I understand I will be expected to pay in full for the extended session. I will only be given the invoice that reflects only the first 45 or 60 minutes of the session that was attended. I understand that insurance plan maximums that apply to medical necessity covered services will not apply and will not limit the amount I may be obligated to pay for the proposed service

I understand that if I do not give at least 48 hours notice of cancellation of my appointment, with the exception of legitimat4e emergencies, I will be charged the complete fee for the session. If using a credit card, I agree to an additional 2.8% service fee for credit card charges.

I understand that I have a right to a copy of this form. This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. I understand that in signing this I waive any future right to be reimbursed by my insurance company for services that have already been provided. By signing this agreement, I know that I am creating a binding contract that is legally enforceable against me by the provider.

Client Signature: _____ Date: _____