# Out of Network Insurance Benefits Statement of Understanding and Consent

Patient's Name ___________________________________________
Last First MI
Date of Birth__________________

**Out of Network Insurance Information**

Primary Insurance:____________________ Policy Holder: __________________

Policy Holder's Date of Birth: __________________Patient's relationship to Policy Holder:________________

Member ID __________________ Group # __________________

Authorization #:________________________________ Mental Health Phone #:__________________

**Patient's Consent**
I consent for my therapist to disclose my protected health information (PHI) as required by my insurance company. Furthermore, if my insurance company requires coordination of care with my Primary Care Provider (PCP), I consent for my therapist to disclose my protected health information to my PCP. I have read *Assessment and Counseling Services, Steven Snook, Ph.D., LLC's Policies and Practices to Protect the Privacy of Your Health Information*, and I both understand and approve of its content.

**Financial Responsibility**
*Assessment and Counseling Services, Steven Snook, Ph.D., LLC* will assist in completing and filing any insurance forms which may be utilized for payments for services; however, I maintain full responsibility for paying all charges for services rendered. I understand I will need to provide all required insurance information when checking in for services; all primary and secondary insurances must be identified, and I will need to update any changed insurance information immediately upon the date of change.

I understand that my therapist is not in network with my insurance company and these visits will be covered under the category of Out of Network Benefits. I understand that I will be expected to pay the full amount of the visit until the insurance company approves the Out of Network Benefit coverage in the form of an Explanation of Benefits from the said company. All co-payments, uncovered amounts and unsatisfied deductibles are to be paid at the time services are rendered. *Assessment and Counseling Services, Steven Snook, Ph.D., LLC* does accept payment by cash, check, Visa, MasterCard, and Discover.

Therapists reserve the right to charge their hourly rate of $120 per hour under the following circumstances: returning phone calls to clients and their attorneys, completing affidavits, and writing letters on behalf of clients.

________________________________________________________________
Printed Name of Client Witness

________________________________________________________________
Signature of Client and/or Guardian Date