Active Therapeutic Solutions

**MENTAL HEALTH COUNSELING**

***INFORMED CONSENT***

**Insurance Verification & Billing**

I hereby authorize Active Therapeutic Solutions, acting as Service agent for **Jennifer Baker LPC RPT ACS** and Active Therapeutic Solutions (Facility), to contact my insurance carrier (shown below) in order to determine eligibility for medical services. I understand that my insurance will be billed for services rendered by both **Jennifer Baker LPC RPT ACS** and staff providing mental health counseling under her supervision. I agree that if my insurance carrier issues a check in my name for reimbursement for services rendered by either the Counselors and/or facility, I will within five days of receipt of this check make payment in the amount of said check to the Counselor or facility.

The following also applies to the use of my insurance to cover the cost of services rendered:

**Authorization to Release Medical Information For Billing**

☐ I hereby authorize the release of any information regarding services by the Counselor/Facility to process insurance claims and allow a photocopy of my signature to file insurance claims.

**Assignment of Insurance Benefit**

☐ I hereby authorize irrevocably assignment of payment for my benefits due me for the services rendered by the Counselor and the facility made directly to the Counselor and/or the facility.

**Financial Responsibility**

☐ I understand that I am utilizing an “out of network” provider for the services rendered by the Counselor and facility. Therefore I understand, regardless of my insurance benefits, that I alone am fully financially responsible for the fees for the services rendered, agree to keep a credit card on file and have agreed to implied consent for it to be charged for services. I agree to collect charges which will be added to my past due accounts and to the terms of the Assignment of Benefits policies.

**Authorization for the Release and Gathering of Medical Information for Treatment**

☐ I hereby authorize the above Counselor and facility to obtain and release copies of my medical records and information regarding my medical history, mental or physical conditions for the purpose of further treatment and evaluation

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insured Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insured Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insured Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address of Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Company Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PrimaryInsurance**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any Secondary** Insurance (if so, please state):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ID Number#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Group policy#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Amount of Deductible?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much is met?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Notice of Insurance authorization & Assignment of Benefits to a Provider**

An assignment of benefits is an arrangement by which a patient requests that his or her health insurance benefit payments be made directly to a designated person or facility, such as a physician or other healthcare professional.

Please be advised that the patient’s signature or, in the case of a minor or mentally handicapped individual, the signature of a parent or legal guardian, provides for the assignment of benefits to Active Therapeutic Solutions authorizing this transfer of payment from the insured to the healthcare provider.

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Print the full name of the undersigned]

hereby authorize Active Therapeutic Solutions to apply for benefits on my behalf for services rendered to me or my dependent(s) and request that payment made by my insurance company be sent directly to Active Therapeutic Solutions. I understand that Active Therapeutic Solutions does not participate with my health insurance carrier and will therefore bill as an out of network provider.

 I certify that I (or my dependent(s)) have active and valid insurance coverage and have supplied Active Therapeutic Solutions with up-to-date and correct insurance identification card(s) as well as all necessary information regarding the guarantor and the subscriber(s) eligible for insurance benefits. Failure to provide updates to any of the information supplied may result in denial of payment to Active Therapeutic Solutions.

 I understand that it will be my responsibility to pay Active Therapeutic Solutions for those medical services rendered to me or my dependent(s), regardless of whether or not paid by insurance. I understand that if I receive a check from my insurance carrier it is my responsibility to immediately pay that amount to Active Therapeutic Solutions.

 I understand that that it is my primary responsibility to pay for services rendered to me, and if my account is turned over to an attorney or agency for collection or taken to court, I agree to pay any collection fees, legal fees, court costs, and other expenses incurred as a result of said collection or court date. Further, I understand that there is a $30.00 fee for returned checks.

I understand that Active Therapeutic Solutions will report to commercial credit bureaus only when an account becomes delinquent. Accounts having no payments within 30 days of the initial debt notice are considered delinquent for payment purposes. After 90 days, all delinquent accounts are reported on the consumer credit report and reported to the IRS as income for the client. The debt will remain on the credit bureau report until it is paid in full.

I certify that the information I have reported with regard to my insurance coverage is correct and I hereby authorize Active Therapeutic Solutions to release any information relating to any claim for benefits, in order to process any claim for benefits and to secure the payment of benefits.

I authorize the use of this signature on all insurance submissions. Furthermore, I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

Signature of Client or Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_

Client (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_