

## Insurance Declaration Form - 2018

**THIS DOCUMENT IS REQUIRED FOR YOUR FILE.**

### North Shore Counseling, Ltd.

425 Huehl Rd., #19B  
Northbrook, IL 60062

www.northshorecounseling.com FAX 847.205.0377

Choosing to bill for counseling sessions through your insurance carrier is an important decision you must make. According to federal regulations, you may choose to pay out-of-pocket and NOT bill through your insurance policy. Clients who so opt are called, Self Pay Clients. Should this be your preference, we (North Shore Counseling, Ltd.) would NOT have the authorization to share your records with your insurance company. The decision you make at the outset of services may be changed at any time by completing a new form and updating your file. The rates you pay for services as a Self Pay Client may be higher than the rates you would pay if we were in-network with your insurance company. Should you decide at a later date to bill to your insurance company, your rates for services would reflect either the insurance-rate or Self Pay Client rate at the time services were provided ACCORDING TO YOUR ACTIVE CONTRACT WITH NORTH SHORE COUNSELING, LTD. ON THOSE DATES OF SERVICE.

Here is an example. Let's say you opt to be a Self Pay Client in January and pay for services at \$150 per session for 4 weeks. In February, you may sign a new Declaration and authorize billing insurance. Your February sessions will be billed to insurance, but we will not retroactively change your status from Self Pay Client to Insurance Client for those January dates of service. We would provide you (upon your request) with an insurance-ready receipt which you could submit to your insurance company for reimbursement for the January sessions..

ALL CLIENTS ARE ASSUMED TO BE SELF PAY UNTIL PAGE 2 OF THIS DOCUMENT HAS BEEN COMPLETED AND ACCEPTED BY NORTH SHORE COUNSELING, LTD.

Page 3 of this document is designed to help you communicate with your insurance company about your policy and determine what your out-of-pocket expenses will be. It is not a guarantee of payment. Unless you opt to be designated as a Self Pay Client, you must complete page two of this document.

### **Knowing your out-of-pocket expenses prior to receiving services is your right and your responsibility!**

I opt to be designated as a "Self Pay Client" at North Shore Counseling, Ltd. I will pay for sessions out-of-pocket with cash, check, or credit card, in accordance with my signed contract for services. I do not authorize North Shore Counseling, Ltd., its agents or employees, to share my private information with my insurance company.

I HAVE COMPLETED PAGE 2 OF THIS DOCUMENT, and I would like to seek payment for services through my insurance company. I understand that if North Shore Counseling, Ltd., ("North Shore Wellness Services, Ltd.") is "out of network" with my company or subcontracted insurance vendor/clearing house, I will be responsible for the full rate of services and provided with an "insurance ready" receipt that will contain my diagnosis and other protected information. I accept responsibility for any copays, coinsurance amounts, deductible payments, or any portion of the session fees not covered by my plan. I grant this permission to be effective as of the date of my signature and witnessed by a representative of North Shore Counseling.

\_\_\_\_\_  
CLIENT/CLIENT REPRESENTATIVE'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
NORTH SHORE COUNSELING EMPLOYEE/AGENT

\_\_\_\_\_  
DATE

**INSURANCE INFORMATION REQUIRED FOR 3<sup>RD</sup> PARTY PAYMENT CONSIDERATION.**

Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

Policy ID# \_\_\_\_\_ Policy Group# \_\_\_\_\_

Client's Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Policy Holder      \_\_\_ SELF      \_\_\_ SPOUSE      \_\_\_ PARENT/CHILD

Name of Insurance Company found on the front of the card: \_\_\_\_\_

Any other company names found on the front or back of the card: \_\_\_\_\_

Phone number for Behavioral/Mental Health \_\_\_\_\_

Does your card mention "PRE-AUTHORIZATION" on front or back? YES NO

If YES, what is the phone number listed \_\_\_\_\_

INSURANCE COMPANY'S PAYOR ID (5-digit, can be numbers and/or letters) \_\_\_\_\_

Do you have a Health Savings Account you would like to use towards your out of pocket expenses? YES NO

If YES, bring your card with you at the time of service. Be sure you have the funds in your account to pay for services.

**WE WILL ONLY BILL DIRECTLY TO COMPANIES WITH WHOM WE ARE IN NETWORK.**

We are considered "OUT OF NETWORK" with the following companies. We will provide clients with an "INSURANCE-READY Receipt when the payment is processed, and payments are due at the time of service:

- BEACON HEALTH
- BENEFIT PLAN ADMINISTRATORS
- CIGNA
- HFN
- HUMANA
- MAGELLAN
- MERITAIN
- MEDICAID
- MEDICARE
- HMO PLANS

***This is tricky, because you may have United as your insurance, but BEACON for your mental/behavioral health. Use page 3 of this document to figure out your coverage prior to your first appointment.***

**If your policy is not listed but it is not BCBSIL, Aetna, or Optum (formerly United), we are most likely out-of-network. Use the next page to communicate with your insurance company to find out exactly what your out-of-pocket expense will be prior to your first appointment.**

Use this page to communicate with your insurance company about coverage for mental health services.  
Have your card with you when you call.

Date & Time of call: \_\_\_\_\_ Name of person who takes your call \_\_\_\_\_

Say, "I'm calling to clarify my benefits and coverage for out-patient mental/behavioral health."

The person on the phone will then ask you questions to 'find you' in their system. Be ready to provide the numbers from your card, your date of birth, and your address.

Ask, "Is my therapist, or her group, North Shore Counseling, Ltd., on the Participating Provider List?"

NORTH SHORE COUNSELING, LTD. NPI=1073639126, TIN=20-1179777  
(Also known as North Shore Wellness Services, same NPI & TIN numbers)  
Dr. Victoria Manion Fleming, LCPC, NPI=1225115074  
Ms. Sheryl Dubinsky, LCPC, NPI=1891078895  
Dr. Karla Ivankovich, LCPC, NPI=1205126513

YES -- On the Panel ("In Network") \_\_\_\_\_ NO -- ("Out of Network") \_\_\_\_\_

"Can you tell me the benefit information for my provider?" (clarify IN or OUT of network)

"What is my deductible?" Amount \$ \_\_\_\_\_ "How much has been met to date?" Met to date \$ \_\_\_\_\_

"Is that for family or individual?" \_\_\_\_\_ "Is it per Calendar Year?" Yes/No - Begins \_\_\_\_\_

"What is my Copay?" \_\_\_\_\_ "Is that a fixed amount or percentage?" \_\_\_\_\_

"What is the Effective Date of my policy?" \_\_\_\_\_ "How many visits am I allowed per year?" \_\_\_\_\_ "

"Is Pre-authorization needed?" No/Yes If yes...

"What phone number can my therapist call to preauthorize sessions?" \_\_\_\_\_

"Does my plan cover CPT code 90791 \_\_\_\_\_ 90837 \_\_\_\_\_ 90847 \_\_\_\_\_ "

"Are any diagnoses excluded from coverage? \_\_\_\_\_ Are Z-codes covered?" (e.g., Z63.0) \_\_\_\_\_ "

"What is the company's payor ID?" \_\_\_\_\_ "Do you accept electronic submission?" \_\_\_\_\_

"How should claims be submitted for either payment to my therapist or reimbursement to me?"

FAX \_\_\_\_\_ MAILED TO \_\_\_\_\_

Other instructions:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Verifying benefits does not guarantee payment for services. If preauthorization is required, call your therapist immediately and make sure they know this before your first scheduled appointment!**