For insurance verification, a copy of your insurance card is required.
Please contact your insurance company for prior authorization. Thank you.

☐ New Client ☐ Re-activated ☐ Change

Chart Number ____________________
eFR ____________________

Health Insurance Coverage

Name ____ Date of Birth ________________

Address __________________________________ City _______________ State _____ Zip ________

Phone ___________________________ SS # ________________________ ❑ Female ❑ Male

Can we contact you by phone? ❒ YES ❒ NO Can we contact you via e-mail? ❒ YES ❒ NO

E-mail Address ____

Are you receiving mental health services anywhere else? ❒ YES ❒ NO Dx Code ________________

Primary Coverage Insurance ID# __________________________ Group # ________________

Insurance Company _______________________________________ Effective Date ________________

Address __________________________________ City _______________ State _____ Zip ________

Policy Holder's Name ___________________________________ Phone ________________________

Address __________________________________ City _______________ State _____ Zip ________

Date of Birth _____________ SS#____________________ Employer _________________________

Relationship to Client ❑ Self ❑ Spouse ❑ Child ❑ Other ________________________________

Referral Needed? ❑ Yes ❑ No Claims Phone _______________________________________

Prior Authorization? ❑ Yes ❑ No Authorization # _______________________ Dates ______________

Benefits:--Insurance Pays ________% Client CoPay $_________ Deductible $________ Met? ❑ Yes ❑ No

Limits on Mental Health Services ____

Primary Coverage Insurance ID# __________________________ Group # ________________

Insurance Company _______________________________________ Effective Date ________________

Address __________________________________ City _______________ State _____ Zip ________

Policy Holder's Name ___________________________________ Phone ________________________

Address __________________________________ City _______________ State _____ Zip ________

Date of Birth _____________ SS#____________________ Employer _________________________

Relationship to Client ❑ Self ❑ Spouse ❑ Child ❑ Other ________________________________

Referral Needed? ❑ Yes ❑ No Claims Phone _______________________________________

Prior Authorization? ❑ Yes ❑ No Authorization # _______________________ Dates ______________

Benefits:--Insurance Pays ________% Client CoPay $_________ Deductible $________ Met? ❑ Yes ❑ No

Limits on Mental Health Services ____

For insurance verification, a copy of your insurance card is required.
Please contact your insurance company for prior authorization. Thank you.

☐ New Client ☐ Re-activated ☐ Change

Chart Number____________________
eFR____________________

Health Insurance Coverage

Fee Schedule for Counseling/Psychotherapy Services

Intake Session(90801)--$225; Individual Session (90806)--$130 for 1-hour session; Couple/Family Session (90847)--$130 for 1-hour session; and Group Session (90853)--$60.

Cash, Check, Credit Card (VISA, MasterCard, Discover) or Health Insurance Payment

Insurance (In-Network Provider) includes most major insurance companies including Medicare and Medicaid. I will submit claims to your insurance company for reimbursement – deductibles and copays are due at the time of your session. *Insurance (Out-of-Network Coverage)* payment will be due in full at the time of your session. You will be provided with a "superbill," which is an insurance-ready receipt you can use to collect any out-of-network benefits due to you. You can contact your insurance company for more specific information about your specific information about your benefits and their procedure for submitting claims for reimbursement. *Please note* that many insurance plans require a mental health diagnosis before they will pay for ongoing psychotherapy services. If you chose to submit a claim for reimbursement, this diagnostic information may become part of your health record.

Signature on File for Electronic Billing: Request for Payment

I request payment of authorized *insurance company name* benefits to me or on my behalf for any services furnished me by or in HopeAllianz Inc. I authorize any holder of medical or other information about me to release to *the insurance company indicated above* and its agents any information needed to determine these benefits or benefits for related services. For services furnished to inpatients of a hospital, or SNF, the request is effective for the period of confinement. For services furnished by an HHA under a plan of treatment the request is effective for the plan of treatment. For other services the request is effective until revoked. If a patient objects to part of the request for payment, the provider will annotate the statement accordingly.

Authorization Release of Information to Insurance Company

By my signature below, I hereby authorize the release of all medical information to the insurance company named above as necessary and appropriate to process claims for benefits. Any release of information is understood to follow the standards set by HIPPA and the Data Privacy Act. I authorize payment of all benefits directly to HopeAllianz Inc when using in-network benefits from my insurance plan.

Authorization Release of Information to eFinancialResources (eFR)

By my signature below, I hereby authorize the release of all information to eFinancial Resources (eFR) named above as necessary and appropriate to process claims for benefits. Any release of information is understood to follow the standards set by HIPPA and the Data Privacy Act. If you have questions about HopeAllianz's billing you may email them to cupryna.eFR@gmail.com.

Client Responsibility for Session Fee if Not Received by Insurance Company within 120 Days

I also acknowledge, that I have been informed of the payment policy that if payment by the insurance company is not received by HopeAllianz Inc within 120 days of billing, I will be billed for those charges.

For insurance verification, a copy of your insurance card is required.
Please contact your insurance company for prior authorization. Thank you.

☐ New Client ☐ Re-activated ☐ Change

Chart Number________________
eFR________________

Health Insurance Coverage

Client Responsibility for Charges Not Reimbursed by Insurance Company

I also understand that if my insurance company does not pay HopeAllianz Inc for submitted claims for services, I am fully responsible for that payment (including deductibles, copays and non-covered services). *Please note*: Not all types of therapeutic services are covered by medical insurance. Please check with your insurance company for specific benefit information, authorization for mental health services, and whether services are covered in-network vs. out-of-network.

Client Responsibility for Session Fees Beyond Insurance Company's Authorization

In addition, if my insurance company finds that it is not medically necessary for continuation of mental health services after the authorized number of sessions, I understand that I am responsible for any charges my insurance company does not cover.

Missed Appointment and Late Cancellation Policy—$25 Fee

Insurance companies do not cover charges for missed or cancelled appointments. Therefore, if I cancel an appointment with less than a 24-hour notice or miss an appointment by not showing up, I understand I will be charged a $25 fee. I will be expected to pay this charge at my next appointment or upon receipt of my statement.

______________________________ ________________
Signature Date

______________________________ ________________
Jody L Friesen Grande, PhD LICSW BCD Date

The insurance industry is constantly updating their benefit packages.
Please contact your insurance company to receive accurate information on your mental health benefits, whether for in-network or out-of-network services and obtain an authorization if needed.
If you are using *out-of-network benefits* obtain information on how to submit for your reimbursement.

~Thank You!