**JULIE BUSSMAN, PHD, LP**

THERAPEUTIC SERVICES

2018 Financial Policy

**Health Insurance** I am a network provider for Blue Cross Blue Shield (BCBS), Preferred One, Optum, United Behavioral Health, Medica, UCare, South Country Health Alliance, Medical Assistance (MA), Minnesota Care, and Medicare. If you have insurance, I will do my best to help you receive maximum benefits. Insurance is a contract between you and your insurance company. I am not a party to this contract. My office will call your insurance company to verify your benefits. However, the benefits quoted to me by your insurance company represent only an estimate of your coverage and are not a guarantee of payment. I also expect that you will contact your insurance company yourself to verify coverage of behavioral health services.

I will file insurance claims to your insurance carrier(s) if you have supplied my office with all the necessary information. This office will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, usual and customary charges, etc. This office will contact your insurance company to supply factual information as necessary. You are responsible for the items listed above as well as any services considered “not medically necessary” by your insurance company. If I do not participate with your insurance company, you are responsible for all out of network deductibles/co-pays.

**Private Pay** Payment is due in full at the end of each session. Please view the following discounted rates below to estimate your cost. Payments may be made via cash, check, or credit card. Any checks returned to the office are subject to an additional fee of $30.00.

 **Rates for Services**

* Mental Health Evaluation (120 minutes): $400
* Initial Diagnostic Assessment (60 minutes): $200
* Individual Therapy (45-60 minutes): $155
* Family Therapy (60 minutes): $180

**Insurance Information**

Primary Insurance Company Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Member ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Client’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Subscriber’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If known, deductible amount: $\_\_\_\_\_\_\_\_\_\_\_ Have a co-pay? Yes / No Amount: $\_\_\_\_\_\_\_\_\_\_

*If you have secondary insurance, please complete the following:*

Secondary Insurance Company Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Member ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber’s Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Member Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If known, deductible amount: $\_\_\_\_\_\_\_\_\_\_\_\_ Have a co-pay? Yes / No Amount: $\_\_\_\_\_\_\_\_\_

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*If the client is a child, please read and complete the following\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

If client is a child, do you have (full [ ]  or joint [ ] ) legal custody of your minor child? And if joint custody, can you seek medical services for your child without permission of other parent?

Yes [ ]  No [ ]  If yes, please provide court documentation.

I agree not to leave the premises while my child is in his/her therapy session: Yes [ ]  No [ ]

If divorced and the other parent is the Insurer, you acknowledge and accept payment for co-insurance, deductibles. Unless obtained and can provide written permission from the Insurer that invoices for co-insurance and deductibles are to be sent to them.

**Insurer’s Information (when the other parent is the Insured party):**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Child’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurer’s Name (other parent):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Insurer’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I, the patient or responsible party, have read and understand the Financial Policy and agree to comply with this policy.*

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_