**Carol Montgomery Brosnac, LMFT, Psychotherapist**

**5637 North Figarden Drive, Suite 116**

**Fresno, California 93722**

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**HEALTH INSURANCE INFORMATION FORM**

*I am requesting that Carol Montgomery Brosnac, LMFT file mental health medical claims to my insurance company on behalf of myself/my dependent. All information obtained in this form will be held as confidential.*

Name of Person Being Treated:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\* A COPY (Front and Back) OF THE MEDICAL INSURANCE CARD IS REQUIRED FOR PROCESSING \*\*

Subscriber (Insured) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MM DD YYYY

**Subscriber Contact Telephone Numbers:**

Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Insurance**

Medical Carrier Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Out-Patient Mental Health Carrier Name (may be different from Medical Carrier): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Outpatient Mental Health Carrier’s Billing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Carrier Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Out-patient Mental Health Carrier Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber/Insurance ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I acknowledge the following:**

 Therapist is contracted as an in-network provider with many insurance companies, Managed Care Networks, and EAPs. It is my responsibility, as the insured, to verify prior to any services being rendered, that the therapist is, in fact, an in-network provider for my insurance’s ***out-patient mental health policy***. I understand that this may be a different company than my primary medical insurance company and I have verified that the therapist is a provider for this company.

 Therapist will file medical claims rendered and all balances not paid by my insurance carrier will be billed to me and due within 30 days of receipt of date on bill.

 Therapist can provide me with a Superbill to submit to my insurance provider for partial reimbursement if therapist is an out-of-network provider and my policy for out-patient mental health allows for me to see an out-of-network provider. I understand that it is my responsibility to determine the amount of reimbursement from my insurance provider by contacting them prior to my appointments with the therapist and it is not the responsibility of the therapist to determine this amount. If using this method of payment, it is my understanding that I am responsible for paying the therapist at each session, the entire amount of the services rendered at the time of service, and I am not eligible for a discount due to receiving a reimbursement of charges from my insurance provider. All reimbursements from my insurance provider will be sent directly to me and will not be sent to the therapist.

**Assignment of Medical Benefits**

The undersigned subscriber hereby authorizes, requests, and directs all medical out-patient mental health insurance payments be made directly to Carol Montgomery Brosnac, LMFT – for services provided to myself or to my dependent.

This assignment will remain in effect until revoked by a written request.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name