Midwest
Counseling & Diagnostic Center, Inc.

Insurance Release

Client Information

Name: _____ **Insurance Carrier**: _____

DOB: _____ **Social Security #**: _____

Insurance ID: _____ **Group #**: _____

Employer/School: _____ **Plan Name**: _____

Information of the Insured (if someone other than client)

Name: _____ **Relationship to Client**: _____

DOB: _____ **Gender**: _____ **Phone**: _____

Address: _____

Office Financial Policy

Thank you for the opportunity to be of service. As a courtesy to you, our client, our office will bill your insurance company consistent with this financial policy. Please be advised that insurance coverage is a contract between the client and the client's insurance carrier. There are numerous insurance plans. Midwest, and its clinicians, may or may not be in-network with your individual insurance plan. If utilizing in-network insurance, your co-pay, co-insurance or deductible is due at time of service. Midwest will then submit claims to your insurer, which will process your claims and remit payment to Midwest. If using out-of-network insurance, on the other hand, payment in full is required at time of service. As a courtesy, out-of-network claims are then submitted to your insurance carrier with instructions to remit reimbursement payments directly to you.

We will assist you in maximizing your insurance by attempting to verify available insurance benefits prior to your first visit. **Please be advised, however, that a verification of benefits is not a guarantee of coverage or of payment.** Midwest does not guarantee or warrant the accuracy of its verification of benefits, which is based solely upon preliminary information provided by the insurance carrier. It is the responsibility of the client to know and understand the benefits of his/her particular insurance plan.

Patient Responsibilities

It is your responsibility to notify our office as soon as possible when you have any policy or insurance changes. Failure to do so will result in a denied claim, therefore you are responsible for the balance due. If an insurance company has not settled a claim within 90 days, the patient will be notified and the responsibility for the balance will transfer to the patient. Our office will be happy to provide you with the information we have received from the insurance company regarding non payment of claim(s). Accounts that have no payments for over 120 days may be sent to an outside collection agency. Prompt payment is appreciated.

Disclosure / Agreement

I agree to pay for any and all professional services that my insurance company refuses to pay for, regardless of the reason. This office will file a claim on my behalf. If my insurance company denies payment for any reason, I will be responsible for the balance unpaid (non-covered expense, co-pays, co-insurance, deductibles). Failure of the insurance company to pay within 60 days of filing is, for the purpose of this agreement, a refusal to pay. In the event I do not pay for these or any other services provided me when due, I agree to pay all collection fees. I have read the financial policy and disclosure agreement and I hereby authorize my benefits to be paid directly to this provider's office, realizing that I am responsible to pay non-covered services.

Client Signature _____ Date: ____ / ____ / ____