Psychiatric and Counseling Services

757.229.7927

Client's Name:_____ Therapist:_____

INSURANCE POLICY AND ASSIGNMENT OF BENEFITS

Please read completely and sign below:

I will pay my deductible and/or co-payment at the time of my appointment or complete a payment agreement with my therapist.

I authorize insurance payments to be paid directly to Family Living Institute, and I authorize the release of any treatment information necessary to process claims.

I further understand that Family Living Institute checks on benefits, and files insurance as a courtesy. It is my responsibility to know my policy, any authorization requirements and to verify the benefits for this type of service.

I hereby acknowledge that it is my responsibility to advise Family Living Institute of any insurance coverage changes immediately or accept responsibility for payment of services rendered.

By signing below, I acknowledge that my insurance policy is a contract between me and my insurance company, and it is not a contract between Family Living Institute and my insurance carrier. If for any reason my insurance company does not pay as expected, I am responsible for the remaining balance.

_____/_____ _____

Print **Client's** name Signature Date

Parent/Guardian Signature _____
(if client is a minor)

For **SENTARA, STATE OF VIRGINIA MAGELLAN/GREENSPRING, TRICARE, MCC (CIGNA), TRIGON MANAGED, AETNA, HAI, PRINCIPAL, VALUE BEHAVIORAL HEALTH, TRIGON**, or any other Managed Care Program: ***DID YOU GET PRE-AUTHORIZATION?*** ☐ ***YES*** ☐ ***NO***

Please give your insurance card to the receptionist to photocopy. If **MEDICAID, SENTARA FAMILY CARE, OR HEALTHKEEPERS PLUS,** please remember to give your card to us each **month** to make a copy. Complete this portion with any information that is not on your card.

	Primary Ins.	**Secondary Ins.**
Insurance Company:	_____	_____
Insurance Phone #:	_____	_____
Subscriber:	_____	_____
Subscriber #:	_____	_____
Group / Emp:	_____	_____