PATIENT INSURANCE VERIFICATION

Phoenix Therapeutic

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Please call the 800 phone number on the back of your insurance card and ask the following questions:

Patient Name:_____ Date of Birth: _____ Insurance Company: _____

Patient ID #: _____

1. Name of representative I am speaking with_____ Date_____

2. When did my coverage begin and is it still current, until when?

Beginning Date of Coverage_____ Current: Yes or No
Ending Date of Coverage_____

3. Do I need a referral from my primary care physician (PCP) for behavioral health services services? Yes or No

4. Is Robin Lipsker, LICSW In-Network or a Preferred Provider with my insurance company? Yes or No

5. What are my benefits? SEE Below *There will be different benefits depending on whether the doctor is In-Network or Out-of Network, and whether your plan includes Out-of-Network benefits.*

Behavioral Health:

Office visit: Deductible _____ Met _____ Waived Yes or No
Co-pay $_____ or Co-Insurance _____% Number of Visits or $_____ per year

6. What year is my deductible based on? ▫ Calendar Year ▫ Policy Year

ASSIGNMENT OF INSURANCE BENEFIT AND VERIFICATION ACKNOWLEDGMENT

I acknowledge that the above listed coverage information is valid and correct. I understand that benefit verification is not a guarantee of coverage by my insurance company, and that I am financially responsible for all the services rendered to me by Phoenix Therapeutic and Consulting Services and its practitioners.
I also understand that all out-of-network (non-contracted) insurance billing services provided by Phoenix Therapeutic and Consulting Services on my behalf are performed on a courtesy basis and can be discontinued by either myself or Phoenix Therapeutic and Consulting Services with written notice at any time. I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to the providers(s) at Phoenix Therapeutic and Consulting Services.
A photocopy of this authorization shall be considered as effective as the original. Assignment will remain in effect until revoked by me in writing.

_____ _____ _____

Signature Print Name Date

Must be signed or verification VOID