

**ISI THERAPEUTIC FAMILY SERVICES, L.L.C.**

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## **Insurance Reimbursement Policy**

*Please Read Carefully*

Many of our patients/clients have health insurance and wish to use it to help pay the cost of their visits to our office. Some insurance plans cover the cost of our services. If you wish to use your insurance, please be aware of the following policies.

### **Policies:**

#### **Responsibility for payment.**

Remember, you are responsible for payment in full for any services you obtain from our office. You are responsible for making payment at the time services are made unless other arrangements are made.

#### **Insurance information\_**

You are responsible for letting us know about your insurance coverage and for providing necessary information so we can bill your insurance.

#### **Change in insurance.**

If there is a change in your insurance coverage, you must let us know before coming in to make sure that pre-certification has been obtained from your insurance company. If your insurance coverage changes and you don't notify us in advance, then you will be responsible for the full amount of your bill.

#### **Pre-authorization.**

**If your insurance requires pre-authorization or pre-certification before services are provided, you are responsible for letting us know this and insuring that appropriate pre-approvals are obtained.**

#### **Expiration dates.**

We are asking everyone who has coverage requiring reauthorization to pay attention to expiration dates and remind us of these dates. This will help us make sure that the necessary approvals have been obtained ahead of time.

I understand the above referenced policy and agree to be responsible for any fees not covered by insurance. I agree to call and use the attached forms to see if my insurance will reimburse before first session.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

## INSURANCE INFORMATION FORM

<b>Insurance Coverage:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Therapist collects:</b> <b>CO-PAY:</b>	
<b>Client's Name as Appears on Insurance:</b>	<b>Client's DOB:</b>	<b>Client's SS#:</b>
<b>Insured's Name:</b>	<b>Insured's DOB:</b>	<b>Insured's SS#:</b>
<b>Name of Primary Insurance:</b>	<b>Group Name/#:</b>	<b>Insured's Relationship to Client:</b>
<b>Insurance Policy Number:</b>		
<b>Primary Ins. Employer:</b>	<b>Secondary Ins. Employer:</b>	
<b>Primary Insurance Phone #:</b>	<b>Secondary Insurance Phone #:</b>	
<b>Is there Secondary Insurance:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Insured's Name:</b>	
<b>Name of Secondary Insurance:</b>	<b>Date of Birth:</b>	
<b>Secondary Insurance Policy #:</b>	<b>Secondary Insurance Group #:</b>	
<b>Insured's Address:</b>		
		<b>Insured's Phone #:</b>
<b>Insured: Male or Female</b>		
<b>This insurance covers (please list names &amp; Birth dates of all covered):</b>		
<b>By signing below I give ISI Therapeutic Family Services, LLC permission to file to my insurance.</b>	<b>Please provide a copy of front &amp; back of insurance card.</b>	
<b>Signature:</b>	<b>Date:</b>	

## What to ask your Insurance

You want to know your Benefits and Eligibility for:

- Outpatient Mental or Behavioral Health
- We bill as an office not a facility (Place of Service Code – 11)
- If your insurance asks if we participate with the local (Alabama) Blue Cross Blue Shield, we DO
  - We are considered IN-NETWORK

ASK:

1. Who is your Behavioral/Mental Health Carrier? \_\_\_\_\_
2. **PLEASE GET GROUP NUMBER:** \_\_\_\_\_
3. How much is my Deductible? \$ \_\_\_\_\_
4. How much have I met of my deductible? \$ \_\_\_\_\_
5. How much is my co-pay? \$ \_\_\_\_\_

NOTE: Your insurance may give you a percentage \_\_\_\_\_%

6. Who can I see?
  - Licensed Professional Counselors (LPC): YES  NO
  - Licensed Marriage and Family Therapists (LMFT): YES  NO
  - Psychologists: YES  NO
7. Can I see a Masters Level provider or does it have to be a PhD? \_\_\_\_\_
8. How many visits do I have per year? \_\_\_\_\_ How many are remaining? \_\_\_\_\_
9. Do I need an Authorization? YES  NO 
  - If YES, ask if you can go ahead and get sessions authorized?
    - If they can't give it to you, PLEASE ask for a phone number for us to contact them to obtain authorization (\_\_\_\_\_) \_\_\_\_\_
  - If YES, how many are they authorizing? \_\_\_\_\_
  - What is the process for authorizing more visits? \_\_\_\_\_

10. Are any of the following codes an exclusion, or require special attention?

- a. 90801    b. 90832    c. 90834    d. 90837    e. 90847    f. 90846    g. 96101    h. 96102    i. 96103

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11. What is the claims mailing address? \_\_\_\_\_

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**Please either save the forms to your computer and email them to isitherapy@gmail.com & sarahisitherapy@gmail.com or print the forms & bring them to your 1st appointment.**