Beth Brawley MA, LPC
Life Without Anxiety LLC
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Insurance Information (PLEASE PRINT)

Name _____ Date of birth _____
Address _____
City _____ State _____ Zip Code _____
Contact number _____
Name of primary insured _____
Date of birth of primary insured _____
Address of primary insured (if different than client) _____
City _____ State _____ Zip Code _____
Primary Insured Place of Employment: _____
Primary Insurance Company _____
ID # _____ Group # _____

Please note:
You are responsible for calling your insurance company and verifying your deductible amount, co-pay, and number of sessions allowed per year.
I understand that if my insurance company does not pay, I will be responsible for missed sessions.
Client signature _____ Date _____
Deductible: _____ Co-pay: _____

Please note:
Insurance companies will not pay for missed sessions. I understand that I will be responsible for the full missed session rate of $50 if I do not give 24 hour notice.
Client signature _____ Date _____

Please read the following section carefully if you plan to use your health insurance.
Please initial each item to indicate that you have read and understand it.
_____ I understand that it is my responsibility to contact my insurance company to find out:
_____What my insurance mental health benefits are (it may vary from your physical health insurance coverage)
_____ What the co-pay and deductible amounts are
_____ If a referral is needed from your primary physician
_____ How many visits per year are allowed under your insurance plan
_____ If your therapist is required to fill out a treatment plan before you can use your benefits
_____ I understand that if my insurance company does not pay, I will be responsible for the balance owed to my therapist.
_____ I understand that when I elect to use my health insurance benefits to pay for psychotherapy services that my diagnosis, symptoms and substance abuse (if any) issues and history will become part of my permanent health insurance records. My insurance company has retained right to access and copy any and all of my records.
_____ I understand that my therapist may be required to fax treatment plans and diagnostic reports to your insurance carrier. In some instances, this information may be submitted to insurance databases and/or employers when they are the purchasers of your medical/mental health benefits.
_____ If I do not understand any of the above items I will ask for clarification.