This form is to make YOU aware of what YOUR insurance does and does not cover and what your financial responsibility are, if any.

PATIENT SELF VERFICATION - INSURANCE BENEFIT COVERAGE

You can bring this form along with the other registration forms, with you the day of your appointment, but please remember to keep a copy for your records.

BEFORE YOU CALL YOUR INSURANCE COMPANY, HAVE READY:

Patient's Name: _____ Date of Birth: _____

Subscriber's Name (spouse/parent): _____ Date of Birth: _____

Insurance Plan Name: _____ ID Number: _____ Group Number: _____

Your chief complaint (some insurance companies may ask you this) _____

WHEN YOU CALL YOUR INSURANCE COMPANY SAY:

I'm calling to verify my insurance for Mental Health/Mental Nervous and or Psychiatric Services in an OFFICE "setting"

Telephone Number you called: _____ Person you spoke with _____

If they ask where you are receiving services: ***Dianna McFarlane, LCSW (Licensed Clinical Social Worker) Tax ID #45-2551058.***

Obtain answers to the following questions:

1. What is my Effective Date of Coverage: _____
2. Do I have a Deductible? ☐No ☐Yes, amount $_____ How much is left $_____
3. Do I have a Co-Pay per visit? ☐No ☐Yes, amount $_____ per visit
4. Or do I have a co-insurance per visit? ☐No ☐Yes: Insurance will pay _____% and I must pay _____%,
5. How many visits are allowed? _____ per calendar or contract year *(circle one)*
6. Is medication management covered? _____ ❒ N/A-I am not coming in for this
7. Is family and/or marriage counseling covered? _____ ❒ N/A-I am not coming in for this
8. Is a referral required? ☐No ☐Yes, *from where?* _____
9. Is an authorization required? ☐No ☐Yes, *from where?* _____

   Telephone number to call to obtain authorization _____

   If you had to obtain an authorization, what is:

   a. Authorization number: _____
   b. Start Date _____ End Date _____
   c. Number of visits authorized: _____

Notes

I have verified that what I am seeking services for is a covered benefit? ☐Yes ☐No, why not _____

Name of person verifying this coverage:

_____ _____

Patient / Parent-Legal Guardian *(circle one)* Date

Please provide your photo ID and insurance card for us to copy. Appointment Date:_____

PLEASE PRINT

NEW Patient Registration Information		
LAST NAME	FIRST NAME	MIDDLE INITIAL

DATE OF BIRTH	SEX	SSN
	☐Male ☐Female	

MARITAL STATUS

☐Single, never married ☐Married, living together ☐Married, not living together ☐Cohabiting with Partner
☐Separated ☐Divorced ☐Widowed

EMPLOYMENT/STUDENT STATUS *(check on from each category, if applicable)*

Employment Status	Student Status
☐Unemployed, not looking for work ☐Unemployed, looking for work ☐FT employed ☐ PT employed ☐Retired ☐ Self-Employed ☐On Welfare ☐Soc Sec Disability	☐Part-Time ☐Full-Time ☐Not a student

Employer Name, if employed:

HOME ADDRESS

House Number and Street Address (apt #, if applicable)	City, State & Zip code

CONTACT INFORMATION

Home Phone	Work Phone	Cell Phone

Email(s)	Preferred Method of Communication
1)	☐ Home Phone ☐Work Phone ☐Cell Phone Would you like to receive appointment reminders via email? ■Yes ☐No
2)	

INSURANCE INFORMATION ***if not using insurance, skip to authorization section***

Insurance Company Name	Policy Number	Group Number

RESPONSIBLE PARTY

This Is the person that is responsible for any unpaid balances (copays, coinsurance and/or deductibles)

Name	Relationship to Patient
	☐ Self ☐Mother ☐Father ☐Guardian

Address	Telephone

I authorize the release of medical information necessary to process this and all claims to my insurance company, including Medicare and Medicaid. I request benefits be made payable to **Dianna McFarlane, LCSW-C.** I acknowledge that I am financially responsible for this and all claims whether or not paid or covered by my insurance company or other organization. I also agree that if my account is referred to a third party for 90 days past due, I will be responsible for the collection agency fee of 35% plus the balance due.

_____ _____

Signature of Patient (Parent/Guardian if minor child) Date