**Lynne Chun, MA LMHC**
**600 N 36th St #321**
**Seattle WA 98103**
**206.794.1661**
**Washington State Mental Health Counselor**
**License #LH 60136263**

# INSURANCE AGREEMENT

Client Name: _____

***Information for insured person (if different from Client)***
Name of Insured: _____
Address: _____
Phone**:** _____

***Insurance Information***
Insurance Company: _____
Member ID: _____
Claims Address: _____

***Plan Information***
Does the plan cover mental health office visits? ___Yes ___ No
Is preauthorization required? ___ Yes ___ No
Are there any limits on the number of sessions? ___ Yes ___ No
What are the out of pocket expenses per visit (copayment, coinsurance) _____
Is there an annual deductible? If so, how much is it? _____
Does the annual deductible apply to mental health office visits? ___ Yes ___ No

***Client Responsibility Statement***

- I understand that my portion of the fee is due at time of service.
- I understand that a no show fee will be charged for appointments cancelled without 24 hours notice. Because insurance does not pay for missed sessions, I will be responsible for the full fee, not just the copay.
- I understand that I am responsible for paying my deductible and any amounts not covered by insurance.
- I understand that if, for any reason, my insurance company does not pay my fee, I am responsible for the full amount.

I authorize the release of information needed to verify and process insurance claims to Lynne Chun MA LMHC.

Client's Name (please print): _____

Signature: _____

Signed by: ___Client ___Guardian* ___ personal representative

* By signing a guardian attests to the fact that he or she has the legal right to sign on behalf of the client.