Dr. Michele Winchester-Vega & Associates
(845) 562-9816 Fax (845) 863-0351

3250 Route 9W
New Windsor, NY 12553

2 Industrial Drive
Florida, NY 10921

WELCOME TO OUR OFFICE

The mission of our caring and compassionate professional staff is to provide welcoming, collaborative, evidenced based effective and cost effective treatment approaches to improve outcomes for those we serve. We respect the complexity and diversity of each individual/family served towards promoting improved mental health, wellness, self-determination, self empowerment, and resiliency.

Please ask the Billing Coordinator if you have any questions about our fees, financial policy, or your requests in dealing with your insurance company. In order to have a satisfactory experience the following guidelines explain how we operate the business aspect of our practice. We are committed to providing you with the best possible care, and are available to discuss our professional services with you at any time. We want to know your experiences, so please feel free to provide feedback to our staff.

CONFIDENTIALITY

We recognize the privilege of confidential communication. By law, information about you will not be discussed with others, without your written consent and knowledge. If you request records to be released, your signature will be required.

I authorize Dr. Michele Winchester-Vega & Associates to contact me at:

Child:

_____ Cell Phone#_____ Can we leave a message? ☐ Yes ☐ No

_____ Home Phone#_____ Can we leave a message? ☐ Yes ☐ No

_____ Fax #_____ Text Messaging ☐ Yes ☐ No

_____ Email address:_____
(Your email address should be set to privacy settings with encryption for HIPPA compliance)

Caregiver / Name:

_____ Cell Phone#_____ Can we leave a message? ☐ Yes ☐ No

_____ Home Phone#_____ Can we leave a message? ☐ Yes ☐ No

_____ Fax #_____ Text Messaging ☐ Yes ☐ No

_____ Email address:_____
(Your email address should be set to privacy settings with encryption for HIPPA compliance)

Caregiver / Name:

_____ Cell Phone#_____ Can we leave a message? ☐ Yes ☐ No

_____ Home Phone#_____ Can we leave a message? ☐ Yes ☐ No

_____ Fax #_____ Text Messaging ☐ Yes ☐ No

_____ Email address:_____
(Your email address should be set to privacy settings with encryption for HIPPA compliance)

Referred By: _____

How do you know them? _____

I would like you to speak with them about my treatment. ☐ Yes ☐ No Phone: _____

Chief Concerns:

Child: _____

_____

_____

_____

Mother:_____

_____

_____

_____

Father: _____

_____

_____

_____

MEDICAL - *CHILD ONLY*

Primary Care Physician: Name_____ Tel:_____

Is Dr. a member of Horizon Medical Group? _____ (Please Complete Medical Collaboration Sheet – Attached)

Conditions/any condition for which you are currently being treated:

_____

_____

Last Physical Exam Date: _____

Medications currently taking (Including over the counter):

_____

_____

_____

Allergies to any medications:

_____

Prior Hospitalizations (Year/Reasons):

_____

_____

_____

Psychiatrist: Name:_____ Tel:_____

HEALTH INSURANCE COVERAGE

If you would like us to bill your insurance company, we will do so as a courtesy to you**. Please notify us of both your primary and secondary insurance.** Any changes to your insurance coverage, including termination, must be brought to our attention. A change in insurance carriers will affect your benefits and payment schedules. Your therapist may be required to obtain pre-authorization for treatment services. If you fail to report any changes and insurance claims are subsequently declined for payment, you will be billed the regular session fee.

_____ _____

Initials - Caregiver Initials - Caregiver

In the event my insurance should send a payment directly to me instead of Michele Winchester-Vega & Associates practice, I will endorse the check and immediately forward to the therapist along with an explanation of benefits (which reflects the dates of services rendered) If I am unable to provide an endorsed check, (if check is for multiple providers), I will send payment for the same amount as issued by my insurance company.

I would like Billing Coordinator to bill my insurance company and will provide all billing information by 2nd session.

Caregiver:
I have primary insurance with _____

I have secondary insurance with _____

Caregiver:
I have primary insurance with _____

I have secondary insurance with _____

CANCELLATION AND MISSED APPOINTMENTS

Please keep all your scheduled appointments so your counselor can monitor your progress and treatment. Sessions are 45 minutes, unless otherwise agreed upon. Your time has been reserved for you. **Due to the overwhelming need for patient appointments, please cancel at least 24 hours prior to your scheduled appointment, so that we may offer that time slot to other patients**. **Missed appointments and late cancellations (less than 24-hours notice) will be billed at $65.00 out-of-pocket fee, as we are unable to bill your insurance for no shows**.

_____ _____

Initials - Caregiver Initials - Caregiver

PLAN BENEFIT AND ELIGIBILITY

It is your responsibility to contact your insurance company to verify coverage and benefit eligibility for outpatient mental health treatment. You need to verify your percentage of payment per visit, any copayments, or deductibles and limits of visits per calendar or benefit year. If you are accessing out-of-network benefits, it is important to confirm that this benefit is available to you. **The practice will make every effort to collect payment from your insurance company. However, you are ultimately responsible for the amount due.**

Fees are based on professional services provided and the amount for time involved. Please feel free to discuss finances openly with therapists and/or my Billing Coordinator. When multiple services are provided, fees for each service will be itemized (i.e., telephone sessions, preparation of special forms, reports, court time, etc.) The fee for these services should be discussed with us at the time of request, as some will not be covered by insurance.

All co-payments, and deductibles are due for services at the time of the visit. Insurance contracts restrict us from waiving copayments. We offer debit and credit card processing, and payment by personal checks as a courtesy to you. If a check is returned for insufficient funds, you will be charged the bank fee in addition to the amount of the check. If insurance benefits pay you directly, you must forward these checks to our office.

After the insurance company has paid their portion of your claim, should your financial responsibility be unpaid after 90 days (unless other financial arrangements have been made) the account will be turned over to a collection agency. Collection agencies charge 33% of the unpaid bill. Should these additional costs be incurred, you will be responsible for them in addition to any unpaid balance.

I authorize the release of any medical information necessary to my insurance carrier to process claims. I permit a copy of this authorization to be used in place of the original. I hereby authorize Michele Winchester-Vega, LCSW, PLLC to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to Dr. Michele Winchester-Vega & Associates. I certify that the information I have reported with regard to my insurance coverage is correct. I understand **that if I fail to** report any changes to my insurance coverage, including termination, I will be responsible for any unpaid balances on my account.

Please sign below indicating that you have reviewed and understand these guidelines. A copy of these procedures will be provided to you upon request.

_____ _____

Child Date Therapist's Signature Date

_____

Caregiver Date

_____Caregiver Date

Dr. Michele Winchester-Vega & Associates, 3250 Route 9W, New Windsor, NY 12553 * 2 Industrial Dr, Florida, NY 10921
Tel: 845-562-9816, Fax: 845-863-0351

Dr. Michele Winchester-Vega & Associates Patient Information

NAME (LAST, FIRST, M.I.)	SS #	
ADDRESS (P.O. BOX) STREET, CITY, STATE, ZIP)	DOB	GENDER M F
HOME PHONE ( ) WORK PHONE ( ) CELL PHONE ( )	EMAIL:	
EMPLOYER OR SCHOOL NAME	OCCUPATION OR GRADE LEVEL	
EMERGENCY CONTACT NAME/PHONE	RELATIONSHIP TO PATIENT	
PRIMARY PHYSICIAN NAME/PHONE	Group Dr. Affiliated with?	

Policy Holder Health Insurance Information – FOR CHILD

PRIMARY INSURANCE PLAN NAME ID # POLICY # GROUP #			
INSURANCE ADDRESS	INSURANCE PHONE		
POLICY HOLDER=S NAME	SS #		
POLICY HOLDER=S ADDRESS (P.O. BOX AND NO. STREET, CITY, STATE, ZIP	DOB	GENDER M F	
POLICY HOLDER=S EMPLOYER NAME	RELATIONSHIP TO PATIENT		

SECONDARY INSURANCE PLAN NAME ID # POLICY # GROUP #			
INSURANCE ADDRESS	INSURANCE PHONE		
POLICY HOLDER=S NAME	SS #		
POLICY HOLDER=S ADDRESS (P.O. BOX AND NO. STREET, CITY, STATE, ZIP	DOB	GENDER M F	
POLICY HOLDER=S EMPLOYER NAME	RELATIONSHIP TO PATIENT		

Authorization to Release Information and Assignment of Benefit

I authorize the release of any medical information necessary to my insurance Carrier to process claims and permit a copy of this authorization to be used in place of the original. I hereby authorize Michele Winchester-Vega, LCSW, PLLC to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company be made directly to Dr. Michele Winchester-Vega & Associates. I certify that the information I have reported with regard to my insurance coverage is correct. I understand that if I fail to report any changes to my insurance coverage, including termination, I will be responsible for any unpaid balances on my account.

Signature (Patient or Parent/Guardian)_____

_____ I have been seen in this practice before (_____year).

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.