Asheville Counseling and Training Services, Inc.
A North Carolina Professional Corporation

Consent and Verification of Insurance Coverage for Mariana R. Glass, MA, LCMHC

Client Information:
Name: _____ SS#:_____ Date of Birth: _____
Address: _____ City/State: _____ Zip Code: _____
Telephone (best place to reach): _____ Email: _____
Relationship to Insured: _____

Insured's Information (if "Insured" is different person than "Client"):
Name: _____ SS#:_____ Date of Birth: _____
Address: _____ City/State: _____ Zip Code: _____

Insurance Company: _____ Insured's ID #: _____
Group Policy #: _____ Ins. Co. Phone #: _____

Are your mental/behavioral health benefits handled by Magellan Behavioral Health or another behavioral health company? ___ Yes ___ No

Is pre-certification/authorization required? If so, please state #: _____

Summary of Mental Health Benefits:
Deductible: _____ # Visits _____ Timeframe _____
Co-Pay _____ Co-Insurance _____
Mailing Address for Claims: _____

Informed Consent for Insurance Filing:

As you consider the decision to utilize your health insurance policy to pay for counseling visits, it is important to understand the potential advantages and disadvantages of such a decision.

Potential advantages include but may not be limited to: Utilizing your policy to pay for counseling visits may enable you to better afford counseling services. Additionally, you are utilizing a plan in which you and/or your place of employment have invested in premiums.

Potential disadvantages include but may not be limited to: Your insurance company will receive one or more diagnoses and possibly treatment plans in order to evaluate payment for counseling services. This information may remain permanently on your insurance record and could impact eligibility for and/or cost of insurance policies in the future.

****

I give my permission for Mariana R. Glass, MA, LCMHC to provide information needed to communicate and/or file insurance claims with my insurance provider.

Client Signature: _____ Date: _____

I request that Mariana R. Glass, MA, LCMHC NOT file my session(s) with my insurance carrier for the sole reason of protecting my privacy and confidentiality.
Client Signature: _____ Date: _____

Revised 3/2020