Insurance Opt-Out Agreement

Counseling Associates for Well-Being

ONLY COMPLETE THE FOLLOWING FORM IF YOU ARE CHOOSING NOT TO FILE INSURANCE FOR YOUR VISITS

Patient Information

First Name:	Last Name:	Date of Birth:

I.Authorization

By filling out this form, I, (the above named client) agree that I *do not* wish to use my insurance, for *any services received* with my clinician or in connection with Counseling Associates for Well-Being.

If at any point this changes during the course of my care, I will notify my therapist and the administrative office of Counseling Associates for Well-Being and provide my up-to-date insurance information.

Please take a moment to read and initial the points below:

_____ I have made the decision NOT to use my insurance for my counseling/therapy sessions or I DO NOT have insurance that covers therapy at this time.

_____ I have reviewed my clinician's fees, and agreed to them, and I understand the charges for my services.

_____ I understand that opting out of using my insurance means I must pay out of pocket for counseling/therapy sessions. I further understand that, unless otherwise discussed and agreed upon in advance, payments are due at the time of service.

_____ I have opted not to use my insurance for counseling sessions even if my clinician is in-network with my insurance company.

_____ If I have Medicare, and my clinician is a Medicare provider, I understand that I can *never* go back and file a Medicare claim for the services under this agreement.

_____ I have agreed to let my clinician and the administrative office of Counseling Associates for Well-Being office know if anything changes and I either: obtain alternative insurance and/or decide that I would like my sessions billed to my insurance.

_____ I understand that if I change my mind or get new coverage, I cannot choose to have insurance pay or have claims sent to insurance for any services that occurred PRIOR to the date that you notified us of your change and provided us with your current and correct insurance information. Billing to your insurance will only begin **after** notification of the change.

_____ I understand that, if I opt out of using my insurance, I cannot use the payment of sessions towards my deductible.

_____ I understand that I cannot, *myself*, file for reimbursement from my insurance for any services during the time period under this agreement.

_____ I understand that, if at any point I choose to use my insurance, my clinician and/or Counseling Associates for Well-Being are not liable or obligated to reimburse *previous* sessions covered under this agreement.

Signature: Date:

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