INTRODUCTORY CHECKLIST AND BILLING with INURANCE AUTHORIZATION

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- ☐ **Confidentiality** (and exceptions)
  Process/Content/Therapy/Progress Notes
  My Practice (court order properly served)
- ☐ **Consultation** by LCSW / Other MH Prof
- ☐ **General Practitioner**: Non-Specialized (when/if referrals suggested)
- ☐ **Tx Planning** (ie: Brief Treatment; If not)
- ☐ **Permission to provide Tx** (client refusal & requests for alternatives)
- ☐ **Need for Assessment Tools** **(**which ones and for what dx; and if full psycho-social assessment is recommended – Why?)
- ☐ **Payment, billing, insurance, credit cards,** checks, arrival expectations, cancellation, No Show Fees
- ☐ **Informed Consent** /Assent/Controversial Topics: Minors; Spirituality & Mental Health; Reparative Tx; Dual Relationships; Med Model & Recovery Model; Other Requests:_____
  (Discuss NASW, APA, Literature, exclusions)
- ☐ **Termination** of counseling services
- ☐ **Fl. Patient Bill of Rights**
- ☐ **Magic Wand** – Satir: "The Miracle Question"
- ☐ **BIO**
- ☐ **Articles**:
  - ☐ HIPPA Privacy Policy Statement
  - ☐ Office Set-up
  - ☐ Stress Reduction
  - ☐ Resolving Conflict
  - ☐ Saying Too Much
  - ☐ Sex as Addiction?
  - ☐ Career Expectations
  - ☐ Class Out of Control; De-escalate & Re-Direct
  - ☐ Other: _____

CLIENT INFO & SNAP SHOT

Type "I Agree" after you have read the forms page, and if you also agree to complete non-secure forms online:_____

Intake Date:_____

Cl Name:_____
DOB:_____
Guardian:_____
Address:_____
C, S, Z:_____
Phone1:_____
Cell:_____
Pers Email:_____

Voice Msgs OK? ○Y ○N **Email OK**? ○Y ○N
Texting OK? ○Y ○N

Insurance ID:_____
Employer:_____
Subscriber Name:_____
Sub DOB:_____
Sub Address:_____
Sub C,S,Z:_____
Co-Pay:_____
Deductible:_____
Auth #:_____
Sessions Allowed:_____

Agreement Complete & Signed? ○YES ○NO
Intake & Complaints Form Done? ○YES ○NO
Parental Consent Signed? ○NA ○YES ○NO
Intake Snapshot (this form) done? ○YES ○NO

Ins. Card: ○ **YES** (Copy at Office) ○NO
Photo ID: ○ **YES** (Copy at Office) ○NO

ER Contact:_____
ER Relationship:_____
ER Phone:_____

PRINT FORM BLANK PRINT Completed FORM

PERMISSION TO BILL INSURANCE, to BILL ME, and to COPY IDs & INSURANCE CARDS

Client Information

Nm
DOB
Parent
Addr
CSZ
Ph1
Ph2
EM

Insurance Information

Ins Co. & plcy #
Emplyr
Nm of Insured
Insured DOB
Insured Add
Insured c, s, z
Auth #:

Dx Code:_______________
R/O: ____________________
R/O: ____________________

DOS: _____________	DOS: _____________	DOS: _____________	DOS: _____________	DOS: _____________
DX: _______________	DX: _______________	DX: _______________	DX: _______________	DX: _______________
CPT:______________	CPT:______________	CPT: _____________	CPT: _____________	CPT: _____________
TGH: ______________	TGH: ______________	TGH: ______________	TGH: ______________	TGH: ______________
DOS: _____________	DOS: _____________	DOS: _____________	DOS: _____________	DOS: _____________
CPT:______________	CPT:______________	CPT3: _____________	CPT: _____________	CPT: _____________
TGH: ______________	TGH: ______________	TGH: ______________	TGH: ______________	TGH: ______________
DOS: _____________	DOS: _____________	DOS: _____________	DOS: _____________	DOS: _____________
CPT:______________	CPT:______________	CPT: _____________	CPT: _____________	CPT: _____________
TGH: ______________	TGH: ______________	TGH: ______________	TGH: ______________	TGH: ______________
DOS: _____________	DOS: _____________	DOS: _____________	DOS: _____________	DOS: _____________
CPT:______________	CPT:______________	CPT: _____________	CPT: _____________	CPT: _____________
TGH: ______________	TGH: ______________	TGH: ______________	TGH: ______________	TGH: ______________
DOS: _____________	DOS: _____________	DOS: _____________	DOS: _____________	DOS: _____________
CPT:______________	CPT:______________	CPT: _____________	CPT: _____________	CPT: _____________
TGH: ______________	TGH: ______________	TGH: ______________	TGH: ______________	TGH: ______________

I am, with my signature below, giving Kurt LaRose, MSW, LCSW certain permissions related to my legally protected health information. LaRose has explained confidentiality to me, related to mental health services, and LaRose has made a copy of the Privacy Policy Statement for his office(s) available to me. I authorize Kurt LaRose, MSW LCSW, and his billing designees, to bill me, and as necessary to bill my insurance company (file claims) for third party re-imbursement. LaRose will bill/collect outstanding amounts due after third party payment/nonpayment, and I agree that he can bill me in any other non-payment scenarios where there is a balance due. I understand and agree that non-payment will be resolved via collections, including credit bureau reporting. I understand that my private health information is protected by the receiving party (insurance company and billing agents). Re-imbursement for counseling services is made according to the terms and guidelines between me and my insurance company; the insurance company may not necessarily pay claims. LaRose accepts payment from insurance as payment in full – in accordance with the terms of the insurance company related to private practice insurance claims – as long as LaRose is listed as an "in-network" provider; I agree to pay co-pays and deductibles as set forth by my insurance company. I understand that if my insurance company designates LaRose as an "out-of-network" provider, I must pay LaRose in full, prior to insurance billing, and that any amount over-paid or duplicated by the insurance will be reimbursed to me at the insurance coverage amounts. I understand that if insurance claims are not paid in a timely manner or if the insurance claims are rejected by the insurance company, LaRose will bill me directly and/or he may ask for pre-payment arrangements; LaRose may refer me to an alternative provider if payments cannot be quickly resolved. If insurance payments are delayed (90 days after billing is considered a delayed payment) all future insurance billing processes may be terminated by LaRose and LaRose may elect to withdraw all previously submitted claims from my insurance company with a correspondence to the insurance company stating: *"previous claims submitted by LaRose are now being withdrawn from the insurance company, with the written consent of the named insured, due to a delay of payment that exceeds 90 days. Future sessions for this client will no longer be billed to the insurance company by this provider, as cash payment arrangements have been made with the insured, due to non-payment and non-resolution. Your insured may still elect to file (or re-file) claims with you."* In the process of billing the insurance company I give LaRose (and his designees) permission to disclose private mental health information, including alcohol and drug addiction information (if applicable) to the billing agents and to the insurance company. LaRose will release identifying information about me, including date of birth, address, telephone number, place of employment, diagnosis, diagnosis coding, dates of services, fees charged, fees paid, co-payment information, and what kinds of services were provided with each insurance claim and/or each claim filed with a third party billing agent. In the case of collections or credit bureau referrals, only that which is necessary to file will be released. Claims may be submitted by standard US mail and/or via electronic submission – as required by the insurance carrier and/or as elected by the billing agent working on behalf of LaRose. This release is given so that the insurance company may determine coverage and re-imbursement and to also assist LaRose in collecting, billing, and settling outstanding balances with me or with my insurance company. This release is valid for all services provided by LaRose that are billed to the insurance company, and to me, and it expires one year from today's date.

Printed Name	Signature	Date