Insurance and Billing Consent

Private Pay/Out of Network Election:

Please check the option below if you are not planning to use insurance and sign the bottom of the form.

_____I do not have or do not want to use insurance benefits. I will be responsible for all charges related to the services rendered. Per the No Surprises Act I understand the cost for a standard individual session is $175 per 50 min session, and a family/couple session is billed at $200 per 50 min session. Intake sessions are billed at $250. I understand that due to the nature of services related to psychotherapy there is no maximum total cost that can be provided, and the length and benefit of therapy is based on my participation and willingness to attend. If services are court ordered a separate agreement will be provided. The number of sessions attended is up to the individual. I agree to keep a payment method on file for automatic billing of services. I understand there will be no refund of payments for sessions that have already taken place or for "no show" or "late cancellation" fees.

Insurance Policies

_____ I consent to the billing of insurance, and I agree to pay any deductibles and copays at the time of session. I agree to keep a payment method on file for these charges when applicable. I understand any services rendered that are not covered by insurance, for any reason due to plan rejection, authorization, or coverage I will be responsible in full. I understand that use of insurance is not a guarantee of payment.

Please list all insurance policies, including out of network coverage and Medicare, if accessing a secondary insurance policy such as Medicaid or another insurance plan.

Primary Policy Information

Insurance Company:

Member ID:

Priority:

Policy Group:

Plan Name:

Policy Holder

Client Relationship:

Secondary Policy Information

Insurance Company:

Member ID: Priority:

Policy Group: Plan Name: Policy Holder

Client Relationship:

Tertiary Policy Information

Insurance Company:

Member ID:

Priority:

Policy Group:

Plan Name:

Policy Holder

Client Relationship:

Acknowledgement

I authorize Erin Helleso MSW LISW, and/or her billing agency, to release information to the insurance companies provided on this form in order to submit insurance claims on my behalf. This authorization extends to the extent necessary to obtain payment for the services provided to me, and includes authorization to release information about mental health, substance use, or HIV diagnoses as required. In consideration of the services provided to me, I assign all benefits to Erin Helleso MSW LISW if accepted, and authorize my insurance companies, Medicare, or other third-party payers to make payments directly to Erin Helleso MSW LISW and its affiliates. I understand that I remain responsible for all amounts due by me, including (but not limited to) copays, coinsurance, deductible amounts, and all services not covered by my insurance plan (including those for which I fail to obtain prior authorization), and mutually agreed-upon services or fees that are deemed not medically necessary. I understand that even in the event Erin Helleso MSW, LISW may not be in network for a particular plan, they are required to bill these payers first unless insurance is opted out all together and services are under a private pay agreement.