Synchronicity Counseling Solutions
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Health Insurance Use Guidelines

- Clients should always contact their insurance company directly to verify and monitor deductible amounts, co-pays and/or co-insurance amounts as well as the in/out network status of this provider.
- Co-payment, deductible and /or co-insurance amounts are due at time of service.
- Clients will be billed for any remaining "client responsibility" amount, as indicated on the Explanation of Benefits produced by the insurance carrier, following claim adjudication.
- Clients with a deductible/co-insurance plan may be asked to put a credit card on file to guarantee payment for services rendered. This card may be used to collect missed appointment fees as well as balances more than 30 days outstanding where another payment agreement has not already been reached.
- Please note that insurance companies will not typically pay for missed sessions (i.e. sessions not canceled with 24 hours advance notice). In these cases, clients are responsible for the full negotiated rate.
- When electing to use health insurance benefits to pay for psychotherapy services, diagnosis and symptomology may become part of a client's permanent health record. The insurance company has retained the right to access any and all of the client's clinical record.
- Providers may be required to fax treatment plans and diagnostic reports to insurance carriers. This information may be submitted by the carrier to insurance databases and/or employers when they are the purchasers of health benefits. Clients have most likely waived the right to confidentiality when contracting for benefits with the insurance carrier.
- Please provide immediate notification to Synchronicity Counseling Solutions, LLC if the insurance carrier and/or any information related to a plan changes.
- Please understand that network status with a specific insurance carrier is subject to change. While every effort will be given to provide advance notice of a status change, it cannot be guaranteed.
- If there are any questions related to the above items or using behavioral health coverage in general, please don't hesitate to ask before signing this form.

By signing below, I am indicating that I understand the above guidelines and authorize sessions to be submitted to my insurance company as a potential means of payment.

Client Signature: _____ Date: _____

Parent/Guardian Signature*: _____ Date: _____

Provider Signature: _____ Date: _____

** Required only if client is less than 18 years of age at time of first visit.*