INSURANCE BENEFIT REGISTRATION & VERIFICATION

KoKoRo Counseling & Integrated Health Services P: 832.632.8118 / eF: 713.422.2428

Please print clearly to help avoid billing errors

PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD & DRIVER'S LICENSE WITH YOUR REGISTRATION

NOTE: You will be billed for missed appointments not cancelled with at least a 48 hr voice confirmed notice.

_____

Patient's Last Name **First** **MI**

_____

Mailing Address **Apt or Unit #**

_____

City **State** **Zip**

_(_____)_____

Home Telephone **Cell Number** **e-mail**

_____

Date of Birth **Age** **Social Security #**

Marital Status: Single Married Divorced Other **Sex: Male Female**
Employment Status: Employed Full Time Employed Part Time F.T. Student Unemployed Retired

Employer Name, Address, Ph & Position: _____

_____

GUARANTOR NAME-(*Person to Bill if Other Than Patient*): _____SS#: _____-___-_____
Guarantor's Date of Birth: _____Guarantor's (Subscriber's) Benefit I.D.:_____

_____

Mailing Address **Apt or Unit #**

_____

City **State** **Zip**

Assignment and Release*: I hereby authorize and direct my insurance benefits, if applicable, to be paid directly to KoKoRo Counseling & Integrated Health Services. I understand I will be held financially responsible for any and all non-covered services provided by any affiliate provider (s) of KoKoRo Counseling & integrated Health Services. Statements will be provided on request. O*pen balances not reimbursed by my benefit carrier will be charged to my credit card on file or deducted from deposit held on file per the amount indicated on my benefits EOB. I understand & give my authorization for Non-emergency "No Shows" or cancellations not voice confirmed with greater than 48hr notice (business days) will be charged to my credit card on file and are not reimbursable by your insurance carrier. My signature below also indicates my understanding that a verbal approval by my insurance is not a guarantee they will pay for services. I understand I am financially responsible for billed services in full if my insurance carrier denies payment.

Signature: _____ Date: _____

PLEASE COMPLETE THE SECTION BELOW REGARDING YOUR INSURANCE INFORMATION

Insurance Company: _____ Subscriber's Birthdate:_____

Subscriber's Name: _____ Group #: _____

Subscriber's ID#: _____ Is Authorization Needed: YES NO

Authorization #: _____ # of Visits Approved: _____

Auth. Date Range _____/_____/_____ to _____/_____/_____ Approved Code(s):_____

KoKoRo Counseling & Integrated Health Services
Healthy-Living/Wellness Training, Coaching, Counseling
P.O. Box 70494 Houston, TX 77270 PH: 832.632.8118 yourwellbeingmatters@gmail.com

Client Worksheet
Insurance Verification & Pre-Certification Authorization Form

Fax completed form to 713.422.2428 & notify office. Fax must be received to confirm your first appointment

The information below must be completed in order to use your insurance benefits. If this section is not filled out& faxed to us, it is understood insurance won't be used and you will be pay the full fee at the time of service.

If you intend to use your insurance for mental health counseling, call the customer service number on your insurance card and find out the specifics of your coverage & complete all information below. In some cases, this will involve a behavioral health provider network and/or a utilization management company providing any required pre-certification, authorization and benefit payments and may be different from your insurance company (ie: your card may say BCBS, yet 'Compsych' may provide the mental health benefits.) In addition, if provider services are limited to a restricted panel, you must verify whether KoKoRo Counseling & Integrated Health Services is recognized as an "in-network" member of that provider group. If you were referred or recommended to our therapist or counseling group and we are considered an "out-of-network" provider you may still receive benefit coverage and reimbursement for services and simply pay any difference, similar to traditional medical insurance coverage.

Your Name: _____ D.O.B:_____

Behavioral health management company name: _____

Insurance Provider Line Phone Number (including area code): _____

Your mental health ID # (if different from your insurance plan ID #): _____

Your mental health Group #:_____

Client Co-pay (per Session) $_____ or % of fee client pays $_____# sessions/yr: _____

Ask for your Allowable Rates for 90791: $_____ ; 90834: $_____ ; 90837: $ _____

ASSESS Code #96101 Covered: YES / NO; Pre-cert Required: YES / NO ; Does Deductible Apply YES / NO

Plan Deductible (if any) $_____Deductible already paid $_____ as of Date:_____, 20____

EAP/Treatment authorization number (if applicable)_____

Number of sessions authorized_____/code_____

Circle Covered codes: 90791/ 90832/ 90834/ 90837/ 90846/ 90847/ 90853/ 90785 / 90876 / 97770 / 96116
(#session allowed wkly:____; Bundling allowed: Y / N; More than 1 unit daily: Y / N)

Claims are mailed to: (Full address):_____
_____

NOTE: PAYMENT IS DUE AT THE TIME OF SERVICE. THERE IS A $39 EMR CHART SET-UP/DIGITAL MEDIA FEE REQUIRED OF ALL NEW CLIENTS PRIOR TO THE FIRST SESSION.

Please FAX or Upload a Copy of your Insurance card & Driver's License