CONSENT TO USE HEALTH INSURANCE

ID#: ________________________________ For (Circle One) HUMANA or ANTHEM

Your Name as it Appears on Your Insurance Card: ____

Your Date of Birth: _______________________ Relationship to Insured: ________________________________

Insured's Name: ____ Date of Birth: ______________________

Address: ____ City: ___________________ St: ______Zip: ________

Please call your insurance company and obtain the following information before your first appointment:

Date Called: __________________

Total Deductible Amount: ________________ Deductible Met This Year: __________________

Copay Amount: _______________ **OR** Copay %: _________________

I, __________________________________ (Client) authorize Louisville Mindfulness Center to release any medical information necessary to my insurance company for me to access my benefits. I understand for me to use my insurance benefits; a diagnosis will need to be assigned to me.

I understand **I am responsible to pay a co-payment of ($ or %) __________ per session at the time of service**.

I understand **services provided may not be covered through Health Insurance**. This may be due to diagnosis or service provided. It is my responsibility to determine if health insurance covers the services provided and will provide reimbursement.

If a deductible is due before insurance will pay benefits, I understand I am responsible to pay each session's contracted insurance rate in full to Louisville Mindfulness Center until that deductible is met. I am also responsible for alerting provider when deductible has been met and co-payment changes.

In addition, I am responsible for all fees NOT paid by insurance, for any reason. If a balance occurs on my account, I agree to a late fee of $25.00 per week, from the last service rendered without payment, until my balance is paid in full.

By signing below, I agree to the above stated terms.

Signature: ____ Date: ____________________