

# THERAPY SERVICES with Dennis Dyck, Ph.D

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## Insurance Information and Authorization Form

Many health insurance companies cover a portion of the cost of therapy sessions and psychological testing. However, as insurance benefits have become increasingly complex, it is often difficult to determine exactly what mental health benefits are available. Some plans also require authorization before they will allow reimbursement. Thus, it is very important that you find out from your insurance company what services are covered and if preauthorization is required. We will assist you in the proper billing of your insurance company. Our office will attempt to check your insurance coverage, but we are not always given accurate information. ***In all cases, you are responsible that your account is paid in full.***

Your contract with your health insurance company may state that your mental health coverage is limited to “medically necessary” services. Each insurance company has its own definition of medical necessity. If your condition does not meet their definition, your services might not be covered. Your insurance company may also require a specific type of therapy or specific therapy goals. You and your therapist will need to discuss the nature of your problems and try to set specific goals for treatment that falls within your insurance company’s guidelines.

Note: Insurance normally does not cover fees for late cancellations, no shows or telephone consultations.

Generally, identifying information, dates of service, type of service and diagnosis is required for insurance coverage. Some plans also require background information about you, more detail about your problems and diagnoses, and our treatment plan. Rarely, they may require that we send them your entire clinical record. Your insurance company will decide, based upon the information we send them, whether they will cover our services. If they approve further sessions, they might assign us a specific number and require us to work on your problem as intensely as possible with the focus of eliminating acute symptoms. We will work with you to accomplish the identified goals in a cost-effective manner.

Sometimes people are uncomfortable sharing person information with their insurance company. Should you prefer that we not bill your insurance company, we will respect that.

**Primary Insurance Company:** \_\_\_\_\_

**Subscriber Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Identification #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Group Name:** \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_

**Subscriber Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Identification #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Group Name:** \_\_\_\_\_

Please sign to show that you have read and understand there may be limits to your insurance coverage. Your signature will authorize our office to bill your insurance for services, our office to disclose requested information to your insurance company, and your insurance to reimburse us for those services.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date