Anthem
Insurance Information

PLEASE READ THE FOLLOWING SECTION CAREFULLY IF YOU PLAN TO USE YOUR ANTHEM HEALTH INSURANCE

Please initial each item to indicate that you have read and understand it:

1. **I understand that it is my responsibility to contact my insurance company to find out:**
   a. **What my insurance mental health benefits are (it may be different than your physical health insurance coverage)_____**
   b. **What the co-pay and deductable amounts are_____**
   c. **If a referral is needed from your primary physician____**
   d. **How many visits per year you are allowed under your insurance plan____**
   e. **If your therapist has to fill out a treatment plan before you can use your benefits____**

2. **I understand that if my insurance company does not pay, I will be responsible for the balance owed to my therapist. _____**

3. **I understand that when I elect to use my health insurance benefits to pay for psychotherapy services that my diagnosis, symptoms and substance abuse (if any) issues and history will become part of my permanent health insurance records. My insurance company has retained the right to access and copy any and all of my record. ______**

4. **Your therapist may be required to fax treatment plans and diagnostic reports to your insurance carrier. In some instances, this information may be submitted to insurance databases and/or employers when they are the purchasers of your medical/mental health benefits. You have most likely waived your rights of confidentiality when you signed up with your insurance company. ____**

5. **If I do not understand any of the above items I will ask for clarification _____**

____ ______________________
Name Date

____ ______________________
Name Date

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(PLEASE PRINT)

NAME____________________________________ BIRTH DATE: ________________________

ADDRESS: ____

CITY: _______________________ STATE___________________ PHONE: ______________

WHOSE INSURANCE IS THIS?____

BIRTH DATE OF
INSURED:____

ADDRESS OF INSURED (IF DIFFERENT THAN CLIENT)

CITY: ______________________ STATE___________________ PHONE: _______________

INSURED PLACE OF EMPLOYMENT: ____

ANTHEM ID # ____

ANTHEM GROUP # ________________________

PLEASE NOTE:
YOU ARE RESPONSIBLE FOR CALLING YOUR INSURANCE AND VERIFYING, YOUR DEDUCTABLE AMOUNT, CO-PAY, AND NUMBER OF SESSIONS ALLOWED PER YEAR.

I UNDERSTAND THAT IF MY INSURANCE COMPANY DOES NOT PAY, I WILL BE RESPONSIBLE FOR MISSED SESSIONS.

____
SIGNATURE

DEDUCTIBLE: _____________________________ CO-PAY_______________________

SESSIONS PER YEAR ____

PLEASE NOTE: INSURANCE COMPANIES WILL NOT PAY FOR MISSED SESSIONS. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR THE FULL INSURANCE RATE IF I DO NOT GIVE 24 HOUR NOTICE

____
SIGNATURE

NewPaths, LLC
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