Bellosa Counseling, LLC
350 S. Northwest Highway, Suite 300
Park Ridge, IL 60068
Phone: 847.656.5259
Fax: 847.656.5201
Email: Christine@BellosaCounseling.com

INSURANCE DECLARATION FORM

(THIS DOCUMENT IS REQUIRED FOR YOUR FILE)

Choosing to bill for counseling sessions through your insurance carrier is an important decision you must make. According to federal regulations, you may choose to pay out-of-pocket and NOT bill through your insurance policy. Clients who so opt are called, Self Pay Clients. Should this be your preference, we (Bellosa Counseling, LLC) would NOT have the authorization to share your records with your insurance company. The decision you make at the outset of services may be reversed at any time by completing a new form and updating your file.

However, please note that the rates you pay for services as a Self Pay Client may be higher than the rates you would pay if we were an in-network provider with your insurance company. Should you decide at a later date to submit bills to your insurance company, your rates for services would reflect the insurance-rate or Self Pay Client rate AT THE TIME SERVICES WERE PROVIDED ACCORDING TO YOUR CONTRACT WITH BELLOSA COUNSELING, LLC.

(Here is an example. Let's say you opt to be a Self Pay Client in January and pay for services at $150 per session for 4 weeks. You cannot retroactively change your status from Self Pay Client to Insurance Client for those January dates of service at a later date. If you decide to bill insurance for your February sessions, you would need to complete a new form expressing that preference, and your rates would reflect that change for your February sessions and all subsequent sessions as long as that is your expressed preference.)

- I opt to be designated as a "Self Pay Client" at Bellosa Counseling, LLC. I will pay for sessions out-of- pocket with cash, check, or credit card, in accordance with my signed contract for services. I do not authorize Bellosa Counseling, LLC, its agents or employees, to share my private information with my insurance company.

- I would like to seek payment for services through my insurance company. I understand that if Bellosa Counseling, LLC is "in network" with my company, my rates may be discounted according to their contract with my insurance company. I understand that if Bellosa Counseling, LLC is "out of network" with my insurance company, I will be responsible for any copays, coinsurance amounts, deductible payments, or any portion of the session fees not covered by my plan. I grant this permission to be effective as of the date of my signature and witnessed by a representative of Bellosa Counseling, LLC.

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CLIENT/CLIENT REPRESENTATIVE'S SIGNATURE DATE

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BELLOSA COUNSELING REPRESENTATIVE'S SIGNATURE DATE