Advanced Counseling
Rod Limb M.Ed., LCPC, LMFT
2176 E. Franklin Rd. Suite 100
Meridian, ID 83642
Phone: 208 887-6283

Insurance Disclosure and Information Request:

Consent for Purposes of Treatment, Payment and Healthcare Operations
I consent to the use or disclosure of my protected health information by Advanced Counseling (also DBA Communicating Love) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of ADVANCED COUNSELING. I understand that using my insurance or related health treatment may require a Mental Health Diagnosis. Health insurance companies usually require that I diagnose your mental condition and indicate that you have an illness before they will agree to reimburse you. To avoid a diagnosis you must pay cash for services and not use your Health insurance plan.
Having a Diagnosis may disqualify me for some life insurance policies, working in a private or government job that requires security clearances or any military or political position requiring a 100% full bill of health. I further understand that government may disqualify me my rights to bear arms (own a personal weapon) with some diagnosis. I understand that diagnosis or treatment by Rodney Limb or other staff may be conditioned upon my consent as evidenced by my signature on this document.

Advanced Counseling has advised me that certain services provided to me by this office may not be reimbursed by my insurance. I have elected to proceed and have those services provided to me with full knowledge and understanding that any charges incurred, to include telephone contacts and patient no shows/no calls, are my responsibility regardless of insurance status. At my request, a copy of this disclosure will be provided and explained to me.

I request payment of authorized private insurance benefits for any and all services furnished to me be made to Advanced Counseling, on my behalf. I consent to and authorize Advanced Counseling to provide pertinent information to bill my insurance benefits and any other medical information concerning me to release information needed to determine those benefits payable for related services.
If I am not an authorized provider, you may still receive services from me for a fee, but your plan will not reimburse you for the cost of any of my services. Plans often will reimburse for only a limited number of visits per year. If you exceed that limit, you may still receive services from me, but your plan will not reimburse you for the cost of services that exceed their maximum number of visits.
Some health insurance companies may reimburse clients for my counseling services. Those that do reimburse usually require that a standard amount be paid by you before reimbursement is allowed and usually only a percentage of my fee is reimbursable. You should contact a company representative to determine whether your insurance company will reimburse you and the schedule of reimbursement that is used. Should you have any questions and would like assistance my staff may be most helpful.
Health insurance companies usually require that I diagnose your mental condition and indicate that you have an illness before they will agree to reimburse you.

If you have any questions or concerns, feel free to ask. I invite any discussion you desire regarding a diagnosis or information in your file. Please fill out the information on the back of this sheet or attach needed information.

Patient Signature: _____ Date: _____

Guardian/Parent: _____ Date: _____
****(Signing Parent or Guardian of Minor is Responsible for Incurred charges.)**

INSURANCE INFORMATION:

Policy holder insurance information:

Subscriber: Last Name: _____ First name: _____ MI: _____

SSN: _____ DOB: _____ Relationship to client: _____

Home Address if different from client: _____

_____ Single _____ Married _____ Divorced _____Other: _____

Insurance Name: _____ Phone: _____

Policy Number: _____ Group Number: _____

Please provide a copy of your insurance card

EMPLOYEE ASSISTANCE INFORMATION:

Some Employers provide limited counseling sessions as a benefit to their employees. These benefits must be accessed by the employee and pre authorized prior to attending a counseling session. If you have received an authorization please complete the following:

Who is your EAP Carrier? _____

Employer: _____

Have you called for your initial authorization: Yes / No

Authorization Number: _____

Number of Sessions Authorized: _____ Expiration Date:_____

If at a future date you obtain authorization for EAP benefits please notify your counselor with this information prior to beginning your counseling session. Thank you.