Background Information

Today's Date _____

I. Primary Client Name (If couple, family, or group, the one person who will be the identified client):

First Name _____MI_____ Last Name_____M___F___

Home Phone # ( ) _____ Work Phone # ( ) _____ Cellular Phone # ( ) _____

Address _____City_____State_____Zip_____

Mailing address if different from above: _____

Drivers license #_____Date of Birth (DOB) _____ SS# _____

Employer _____ Client E-mail _____

II, Spouses's/Other Client's Information (or if primary client is a minor, give parent/guardian information below):

Relationship to primary client: Spouse_____ Parent _____ Legal Guardian _____ Child _____ Other_____

First Name _____MI_____Last Name_____M___F___

Home Phone # ( )_____ Work Phone# ( )_____ Cellular Phone # ( ) _____

Address _____City_____State_____Zip_____

Mailing address if different from above: _____

Driver's license # _____ Date of Birth (DOB) _____ SS # _____

Employer _____ Client E-mail _____

If we are billing your insurance please fill out the following information completely:

Are you using an Employee Assistance Program (EAP)? _____ yes _____ no If yes, who do we bill? _____

EAP Phone# ( )_____ How many sessions? _____ Authorization # _____

Primary Ins. Co _____ *Grp #* _____ *ID#* _____

Ins. Billing Address _____Ins. Phone # _____

City_____State_____Zip_____

Name of Subscriber _____ Relationship to client _____

Subscriber's Address (if not above)_____ DOB _____

City_____State_____Zip_____ SS# _____

Subscriber's Employer _____ Phone # _____

*Any secondary insurance?(please give complete information)*_____

_____

_____

Signature of person financially responsible for bill: (Include address and Phone # if not above) _____

_____

Have you (or any member of your family) previously been a client of Pearl Counseling Associates, LLC? □ Yes □ No
If yes, is your (or family members) portion of the account with that counselor clear and/or current? □ Yes □ No

PERSON TO NOTIFY IF EMERGENCY:
Relative: _____ Phone: ( ) _____
Name and address of person, organization, or ad that referred you:
_____Phone: ( ) _____

Karen R. Bream, M.A, LMHC
Intake Form

Please fill out the following form for the named client. If the client is a minor, the form should be filled out by the parent or legal guardian.

Date: _____

Client Last Name: _____ **First Name** _____ **MI** ___

Marital Status: Single _____ Engaged _____ Married _____ Re-married _____

Separated _____ Divorced _____ Widowed _____

Ethnicity: Caucasian _____ Latino _____ Asian _____ S.E. Asian _____

Indian _____ American Indian _____ Black _____ Other (Please specify) _____

Other people in the home:

Name	Age/Birthdate	Relationship to Client
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What is your main concern that you want to address in counseling and how you hope to be helped

_____

_____

_____

_____

How would you rate your use of alcohol or drugs? _____ List substances used and how often:

_____

_____

Physician/Health information:

Name:_____

Address: _____

Phone # _____ Date of last physical: _____

Major illness: _____

Medications: _____

Previous Psychotherapy:
Have you ever received psychiatric, psychological, or counseling help of any kind before? _____

If so, briefly describe: _____

_____

_____

Please circle any of the following struggles that pertain to you:

Nervousness	Depression	Fears	Shyness
Sexual problems	Suicidal Thoughts	Separation	Divorce
Finances	Drug Use	Alcohol use	Friends
Anger	Self-control	Unhappiness	Sleep/Nightmares
Religious Matters	Work	Relaxation	Headaches
Tiredness	Legal Matters	Memory	Ambition
Grief/Loss	Compulsive Habits	Decision Making	Loneliness
Inferiority Feelings	Concentration	Education	Career Choices
Health Problems	Temper	Marriage	Stress
Relationships	Children	Thought patterns	Relationship w/parents
Appetite	Impulsiveness	Intimacy	School
Post traumatic stress	Sexual identity	Communication	Anxiety/panic

Please add any additional information which you feel may be useful to us in helping you with your situation: _____

_____

counseling as

KAREN BREAM, MA, LMHC
Individual, Couple & Family Therapy

CLIENT INFORMATION AND DISCLOSURE STATEMENT

KAREN R. BREAM, M.A., LMHC
LMHC CERTIFICATION #LH00006882
SC CERTIFICATION # 239329F

Counselors practicing counseling for a fee must be certified or licensed with the Department of Licensing for the protection of a person's health and safety. Registration of an individual with the Department does not include recognition of any practice standards nor necessarily implies the effectiveness of any treatment.

I am an independent private practitioner. My work as a therapist is solely my responsibility and does not necessarily reflect the views of other independent therapists at Pearl Counseling Associates. You are my client, not Pearl Counseling Associates.

PROFESSIONAL PROFILE

I obtained my Master of Arts degree in counseling from Seattle Pacific University in 1979 and Bachelor of Arts degree from Pacific Lutheran University in 1977. I have been working with families, individuals, children, adolescents, and couples since 1979 in a variety of settings, which include group homes, private practice, schools, and in-home. I have written and taught workshops on parenting and communication. In my professional experience I have been in supervisory and managerial roles as well as clinical roles. Clinical issues I have experience in include relational issues, emotional problems, behavior problems, depression, marital issues, parent-child relationships, communication, sexual dysfunction, anxiety, and cognitive difficulties. I am a Certified Mental Health Counselor and Certified School Counselor in Washington State.

COUNSELING PROCESS

I view the counseling process as an interactive relationship with the goal being to address your needs through a variety of means, depending on my professional discretion and your input and desire. It is my belief that people are doing the best they can in their situations with the skills they have. However, new skills are often needed to address the issues that bring dissatisfaction or pain into one's life. I view my role as presenting new ideas or skills that might address those issues, as well as understanding and listening to your concerns in order to better develop goals that will help you address your needs. I also believe the counseling process can be a healing relationship by helping you discover your own strength and abilities as well as understanding, changing, and dealing with your emotions, relationships, and personal goals. Although I personally adhere to a Christian belief system, I respect and appreciate your rights to address your spiritual growth in whatever manner you have chosen.

CONFIDENTIALITY

Confidentiality is an important element of the therapy process. Your identity and ongoing work in therapy will be kept strictly confidential, with only the following exceptions:

1) State law requires reporting to the proper authorities cases of suspected abuse (child, elder, dependent adult).
2) Threat of harm to self or others (suicidal or homicidal statements) may be reported to family and/or appropriate mental health or law enforcement professionals.
3) Case records and testimony may be subpoenaed by court order.
4) Professional consultation and/or supervision.
5) Records of insurance clients are subject to scrutiny by their insurance companies in return for claims payment.

By law, information about clients may only be released upon written consent of the persons treated or the person's parent or legal guardian.

FEES

My hourly fee for all billed services is $130.00 except for the first session, which is $150.00 (All insurance claims will be billed at the $150/$130.00 rate) If you are not using insurance and pay in full on the day of service, I will reduce my fee to $130.00 for the first session and $110.00 for the additional sessions. Charges for extended appointments will be assessed according to your hourly rate. This also includes between session telephone calls lasting over 10 minutes. In addition, if we believe that it would be helpful for me to consult with another paid professional regarding your situation; you will be responsible for all fees, including my time. If you believe your health insurance will cover my services, please supply me with all the necessary information to process your claims. As a courtesy, our office manager will bill the insurance company for you.

Appointments are generally made on a regularly scheduled basis. In the event you are unable to keep an appointment, a 24 hour notice is required for cancellations. You will be charged full fee for a "no show" and a late cancel fee of 50% of your hourly fee for a cancellation without 24 hours notice.

Financial considerations are a necessary part of counseling. Openness and flexibility are needed when determining a client's financial obligation. It is also my policy to not let a client accrue a balance of more than $250.00 in personal debt (excludes amount owed by insurance). If at such time your balance goes beyond that amount, I can no longer continue to see you in counseling until reasonable effort has been made to reduce your balance. I reserve the right to determine what a reasonable effort is. Bills for which no payment has been made for 60 days will be considered delinquent and may be instituted for collection. The fact of your counselor-client relationship for purposes of billing may be released to appropriate persons for collection of overdue accounts.

DISCLAIMER REGARDING CHILDREN

Unless children are part of the therapy session it is recommended that they not be brought to the office. I am unable to guarantee their safety if left unattended in the waiting room or group room. As well, our receptionist, if present, can not be responsible for keeping an eye on them.

CLIENTS RIGHTS AND RESPONSIBILITIES

The goals and course of therapy are mutually determined. You are encouraged to ask any questions you may have regarding educational or professional background, therapeutic approach, and the specific therapy plan and progress. It is your responsibility to determine whether the services offered are appropriate and ultimately helpful. You have the right to end therapy at any time without additional obligation other than those already accrued.

I trust this information has helped you understand my background, approach to therapy, and policies, as well as your own rights and responsibilities as we begin our counseling relationship. Please sign below to show that you have read, understood, and agreed to the terms previously described in this disclosure.

Client Signature Date

Client Signature Date

Client Signature Date

Client Signature Date

Witness Date

1919 N. Pearl St., Ste. C-1 • Tacoma WA 98406 • Phone: (253)752-1860x329 • Fax: (253)752-1890

Financial Policy
Pearl Counseling Associates, LLC

Private Pay (not using Insurance)

Payment is due at time of service unless you make other arrangements with your counselor. If you do have an alternate agreement with your counselor, please make sure the Office Manager is aware of it.

We accept as payment, Visa/MasterCard, Debit Cards, Checks, Money Orders, Cash, or online banking service. Make checks or money orders payable to your counselor (not to Pearl Counseling). Checks returned for non-sufficient funds (NSF) will be charged back to your account with an additional $18.00 service charge. If you prefer, you can use EASY PAY for billing. In that case, we will maintain your credit or debit card number on file to satisfy all fees charged, including late cancels, no shows, co pays, deductibles, coinsurances or other balances.

Insurance & Insurance Collection

Insurances doing business in the state of Washington have 30 to 90 days to pay or deny a claim. They normally respond in 2-3 weeks' time. If you have paid your account in full and insurance pays at a later date, or you pay more than is owed, you may choose either to receive a refund from your counselor or apply the credit toward future sessions.

It is your responsibility to know what your mental health benefits and financial obligations are with your insurance company. As a courtesy, we will also check on your benefits. Be aware that most insurance plans require you to authorize us to provide a clinical diagnosis, and sometimes additional clinical information. This information becomes part of the insurance company files.

We will bill your insurance for you. Co-pays, if applicable, are due at time of service. If you have a coinsurance (vs a co-pay) you will be billed after we receive the explanation of benefits from your insurer. If your counselor is out of network for your insurance, you may need to pay for the session in full, and then receive reimbursement directly from your insurance company. Note: Having more than one insurer does not necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays.

Late/Missed Sessions: Insurance does not pay for missed sessions, nor for missed time during a session. If you are late or miss a session, insurance will not pay for the lost minutes, and we will need to bill you for the missed time.

Minor Clients: The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment. (If the minor is covered by insurance the policies applicable to their type of insurance apply.) For unaccompanied minors, non-emergency treatment requires that charges be authorized to a Visa/MasterCard/Bank Card, or payment by cash or check at time of service has been verified, or we have the signature on file of the person(s) financially responsible for the bill and they have read and signed this policy.

Divorce Decrees: This office is NOT a party to your divorce decree. Adult clients are responsible for their portion of the bill at the time of service. The responsibility for minors rests with the accompanying adult. An exception may be made if we have a written authorization from a third party, prior to the start of counseling, indicating that they will be responsible for fees billed to them.

Collections / Rebilling Fees: We may charge a rebilling fee of $10.00 per bill on past due accounts (over 30 days). If it becomes necessary to send your account to collections., you will be responsible for all collection fees. An initial fee of $30.00 will be added to your account to start the collections process. Non-emergency counseling sessions will be suspended until your account is paid in full.

On Call Counseling: Pearl Counseling Associates, LLC offers "on call" counseling when crisis or emergency counseling is needed during your counselor's absence. If you meet with an "on call" counselor, payment is due at the time of service, at the counselor's rate. If the "on call" counselor is in network with your insurance and you fill out their intake form, your insurance can be billed.

I have read the Financial Policy. I understand and agree to this Financial Policy:

Client or Responsible Party: _____ **Date**_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. State and federal law protects the confidentiality of this information. "Protected Health Information," (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Your Rights Regarding Your PHI

You have the following rights regarding your PHI that I maintain about you:

Right of Access to Inspect and Copy. You have the right, which may be restricted only in certain limited circumstances, to inspect and copy PHI that may be used to make decisions about your care. I may charge a reasonable, cost-based fee for copies.

Right to Amend. If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.

Right to an Accounting of Disclosures. You have the right to request a copy of the required accounting of disclosures that I make of your PHI.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.

Right to Request Confidential Communication. You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. I will accommodate reasonable requests and will not ask why you are making the request.

Right to a Copy of this Notice. You have the right to a paper copy of this notice.

Right of Complaint. You have the right to file a complaint in writing with me or with the Secretary of Health and Human Services if you believe I have violated your privacy rights. I will not retaliate against you for filing a complaint.

MY USES AND DISCLOSURES OF PHI FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATION

Treatment. Your PHI may be used and disclosed by me for the purpose of providing, coordinating, or managing your health care treatment and any related services. This may include coordination or management of your health care with a third party, consultation with other health care providers or referral to another provider for health care services.

Initials _____

Payment. I will not use your PHI to obtain payment for your health care services without your written authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

Healthcare Operations. I may use or disclose, as needed, your PHI in order to support the business activities of my professional practice. Such disclosures could be to others for health care education, or to provide planning, quality assurance, peer review, administrative, legal, or financial services to assist in the delivery of health care, provided I have a written contract requiring the recipient(s) to safeguard the privacy of your PHI. I may also contact you to remind you of your appointments, inform you of treatment alternatives and/or health related products or services that may be of interest to you.

OTHER USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

Required by Law. I may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. Examples are public health reports and law enforcement reports. I also must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

Health Oversight. I may disclose PHI to a health oversight agency for activities authorized by law such as professional licensure. Oversight agencies also include government agencies and organizations that provide financial assistance to me (such as third party payers).

Abuse or Neglect. I may disclose your PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect. However, the information I disclose is limited to only that information which is necessary to make the initial mandated report. I may disclose PHI regarding deceased patients for the purpose of determining the cause of death, in connection with laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death.

Research. I may disclose PHI to researchers if (a) an Institutional Review Board reviews and approves the research and an authorization or waiver to the authorization requirement; (b) the researchers establish protocols to ensure the privacy of your PHI; and (c) the researchers agree to maintain the security of your PHI in accordance with applicable laws and regulations.

Threat to Health or Safety. I may disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of the public or another person.

Criminal Activity on My Business Premises/Against My Staff or Me. I may disclose your PHI to law enforcement officials if you have committed a crime on my premises or against my staff or me.

Compulsory Process. I will disclose your PHI if a court of competent jurisdiction issues an appropriate order. I will disclose your PHI if you and I have been notified in writing at least fourteen days in advance of a subpoena or other legal demand, and no protective order has been obtained, and I have satisfactory assurances that you have received notice of an opportunity to have limited or quashed the discovery demand.

Initials _____

USES AND DISCLOSURES OF PHI WITH YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your PHI will be made only with your written authorization. You may revoke this authorization in writing at any time, unless I have taken an action in reliance on the authorization of the use or disclosure you permitted, such as providing you with health care services for which I must submit subsequent claim(s) for payment.

THIS NOTICE

This *Notice of Privacy Practices* describes how I may use and disclose your protected health information (PHI) in accordance with all applicable law. It also describes your right regarding how you may gain access to and control your PHI. I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this *Notice of Privacy Practices*. I reserve the right to change the terms of my *Notice of Privacy Practices* at any time. Any new *Notice of Privacy Practices* will be effective for all PHI that I maintain at that time. I will make available a revised *Notice of Privacy Practices* by sending a copy to you in the mail upon request, or providing one to you at your next appointment.

CONTACT INFORMATION

I am my own Privacy Officer. So, if you have any questions about this *Notice of Privacy Practices*, please contact me. My contact information is:

Karen Bream, MA, LMHC
1919 N Pearl St., Ste. C-1
Tacoma WA 98406
(253) 752-1860 x329

COMPLAINTS

If you believe I have violated your privacy rights, you may file a complaint in writing to me, as my own Privacy Officer, specified on the first page of this *Notice*. I will not retaliate against you for filing a complaint. You may also file a complaint with the U.S. Secretary of Health and Human Services.

The effective date of this notice is April 14, 2003

ACKNOWLEDGMENT

I hereby acknowledge receiving a copy of this notice.

_____

Client's Signature *Date*

_____

Client's Signature *Date*

Karen Bream, MA, LMHC
Pearl Counseling Associates, LLC
1919 N Pearl St., Ste. C-1, Tacoma WA 98406
Office: (253) 752-1860 x **329**, FAX: (253) 752-1890

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR INSURANCE CLAIMS PROCESSING

TYPE OF INFORMATION TO BE DISCLOSED

I hereby authorize **Karen Bream and/or her billing representative** to use and/or disclose the following protected health information: **Please initial.**

- ❑ _____ Information required to process manual claims
- ❑ _____ Information required to process electronic claims

ASSIGNMENT OF BENEFITS (Please initial)

- ❑ _____ I authorize my insurance benefits to be paid directly to the provider.

INSURANCE COMPANY TO WHICH PROTECTED HEALTH INFORMATION WILL GO

Name_____

Address: _____ Business Phone: _____

City: _____ State: _____ Zip: _____

REVOCATION AND REDISCLOSURE

It is my understanding that this authorization can be revoked in writing at any time, except to the extent that substantial action may have already occurred based on prior authorization, and/or including provision of health care services requiring disclosure to effectuate payment. Unauthorized re-disclosure by recipient is a potential risk.

DURATION

If not previously revoked, this authorization will expire one (1) year from date signed below.

***Specific Limitation**:* Except as to third-party payers, this authorization does not include disclosure for future health care services received more than ninety (90) days from date of last signature.

SIGNATURE

This Authorization covers protected health information pertaining to *(client)* _____.
Signature below authorizes use and/or disclosure of protected health information in accordance with the foregoing from the Date of that signature (initial or renewal). I acknowledge that I am responsible for any balance due. I agree that I will not withhold or delay payment because of any insurance/third party involvement.

Signature: _____ Date: _____

Patient/Parent/Guardian/Other legal representative for health care decisions: _____

Renewal Signature: _____ Date: _____

Witness: _____ Date: _____

PEARL
counseling associates LLC

KAREN BREAM, MA, LMHC
Individual, Couple & Family Therapy

Court Release Acknowledgement

I understand that I, _____ am receiving therapy from Karen Bream. I understand that Karen Bream is providing behavioral/metal health treatment and is not acting as an evaluator.

I further understand and agree not to involve Karen Bream in legal disputes, as I understand that would not be in the best interest of my treatment and would be counter-productive to the therapeutic process.

I agree not to involve Karen Bream in court proceedings regarding any treatment now or in the future, nor will Karen Bream be asked to share my records regarding any such proceedings.

_____ _____
Client Signature Date

_____ _____
Therapists Signature Date

PEARL
counseling associates LLC

KAREN BREAM, MA, LMHC
Individual, Couple & Family Therapy

Please skip this form if client is not a minor

(For Parent or Guardian of Minor)

Court Release Acknowledgement

I understand that my child _____ is receiving therapy from Karen Bream. I understand that Karen Bream is providing behavioral/metal health treatment and is not acting as an evaluator.

I further understand that Karen Bream is not conducting a custody or visitation evaluation for my child. I agree not to involve Karen Bream in any custody or visitation disputes, as I understand that would not be in the best interest of my child's treatment and would be counter-productive to the therapeutic process.

I agree not to involve Karen Bream in court proceedings regarding any treatment of my child now or in the future, nor will Karen Bream be asked to share my child's records regarding any such proceedings.

_____ _____

Parent / Guardian Signature Date

_____ _____

Therapists Signature Date

Client Easy Pay Consent

(Optional payment plan for those paying by credit/debit card)., This form is for those who wish us to keep your debit/credit card number on file and we will automatically deduct any payments owed from your debit/credit card. (Examples of payments deducted are copays, deductibles, coinsurances, late cancels, no-shows or full payment if not using insurance).

I authorize **Karen Bream, MA, LMHC** to charge my credit/debit card for fees charged (including late cancels and no shows) and if using insurance, copays, coinsurances, deductibles and the balance of charges not paid by insurance within 90 days.

Not to exceed $ _____ per

- ❑ Month (day of month _____)
- ❑ Semi-monthly (the 15th and the last day of the month)
- ❑ Week (day of week _____)
- ❑ Each session

Insurance clients: (Don't sign this unless you are using easy pay <u>and</u> have insurance)

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider. I understand that if my insurance should pay at a later date I may choose either to have a refund issued by my counselor or use it as a credit towards future payments owed.

_____ _____

Cardholder Signature Date

Patient Name		
Cardholder Name Exactly as it Appears on the Card		
Cardholder Address		
City	State	Zip

☐ Visa ☐ MasterCard ☐ Visa Debit Card ☐ Mastercard Debit Card

Credit Card Number _____

Date of Expiration _____/_____/_____ V-code (3-digit security code on back of card) _____

Cardholders Signature _____

INSURANCE QUESTIONNAIRE

While we bill the insurance company for you as a courtesy and help facilitate your receipt of benefits, we are not responsible for whether your insurance company pays or not. To help you receive the best information regarding your mental health benefits, please contact your insurance company and ask the following questions. (These questions should be asked of each insurance policy you wish us to bill and for each family member that is seeing a counselor separately.)We ask that if you have not obtained this information before coming into our facility, that you please do so by your second session. Even though mental health benefits fall under the medical category, do not assume that you have benefits or that your benefits are the same for mental health as they are for medical expenses (they usually are quite different).

Do I have mental health benefits on my policy? If additional members of my family are seeing the counselor separately, do they have the same benefits?

If yes,

1) Is my counselor covered under my policy? (Be sure and get your counselor's credentials. My counselor's credentials are **MA, LMHC, Licensed Mental Health Counselor**. (Some insurances will take only and MD, PhD, or licensed agency. Pearl Counseling Associates,LLC is not a licensed agency.) Is my counselor a preferred/participating provider or considered out of network? If my counselor is not preferred/participating, do I have out of network benefits? Are out of network providers with my counselor's credentials covered? Does my counselor need direct supervision by a MD or PhD to be covered?

2) Is this an EAP (employee assistance program) or am I using my regular insurance policy only (or both)? [If EAP, has my counselor been sent a packet for billing (If so, check with counselor to see if received)? How many sessions has my EAP approved? After my EAP sessions are finished, and I wish to continue, can I continue with my current counselor or do I need a referral?]

3) What are my deductible and/or co pay/coinsurance? (Have I met my deductible for the year? If not, how much do I still owe? When does it start over again?)

4) Do I need preauthorization, a referral from my physician (ex: family doctor) or a gatekeeper (ex. Magellan, MHN, HMC), for any or maximum benefits? If yes, questions to ask your physician or gatekeeper.
   a) How many sessions will they allow me to begin with?
   b) If necessary, who obtains the extension on the authorization?
   c) How soon will my insurance company receive the authorization so my sessions will be covered? (Client should check with insurance company a few days after expected date of receipt to see if authorization has been received.)
   d) What are the start date and ending date of my authorization? Will it cover sessions I've already had?

5) How many sessions will my insurance cover or what is the maximum dollar amount per year my insurance company will allow?

6) What are the exclusions on the policy, if any? Will my presenting issue be covered? (ex: often marriage and family issues are not covered).

7) What is the correct insurance address to send claims to? Is it different than what's on my card? Is it different for a preferred provider vs. an out of network provider?