Elizabeth M. Rapkoch, PsyD
Licensed Psychologist

INSURANCE AGREEMENT

Insurance Agreement Policy Summary

- If using insurance, the client is responsible to gather information about and be aware of eligibility for mental health benefits, deductibles, co-payments or co-insurance, session limits or other restrictions affecting reimbursement. Clients are responsible for obtaining authorization for services, if necessary. *Obtaining authorization for services is particularly important for psychological evaluations as many insurance companies are limited in the types of evaluations they will authorize.*
- Clients are responsible for payment of late cancellation and "no-show" fees, as these fees are not covered by insurance.
- Dr. Rapkoch agrees to submit claims on a client's behalf if she is an in-network provider for that insurance company.
- If Dr. Rapkoch is an in-network provider for the primary insurance company and there is secondary insurance, she will process claims for the primary insurance company only.
- If Dr. Rapkoch is not an in-network provider for the client's insurance company, the client is responsible to pay the fee for service in full at the time of service. She will then provide the client with the information needed for them to seek reimbursement from the insurance company directly.
- By signing below the client authorizes Dr. Rapkoch to release to the below listed insurance company any requested client information necessary to process insurance claims per the Informed Consent Agreement.
- Clients are ultimately responsible for payment of services rendered. All other policies from the Fee Agreement apply.

I understand the above policies and agree to abide by them:

_____ _____
Signature of client or client's representative Date

Insurance Information

Primary Insurance Carrier_____ Phone_____
Claim Address_____ City/State _____ Zip_____
Name of Insured_____ Relation to Client_____
Insured ID_____ Group #_____
Insured Date of Birth_____ Phone_____
Employer_____
Insured's Address_____ City/State _____ Zip_____

Secondary Insurance Carrier_____ Phone_____
Claim Address_____ City/State _____ Zip_____
Name of Insured_____ Relation to Client_____
Insured ID_____ Group #_____
Insured Date of Birth_____ Phone_____
Employer_____
Insured's Address_____ City/State _____ Zip_____