Emily Fogle, Psy.D.

1718 Peachtree Street NW, Ste-590
Atlanta, Georgia 30309
(770) 376-7764
emilyfogle@gmail.com

Intake Questionnaire

Patient (or recipient)

Name _____

Date of Birth_____ Age____

Phone Numbers:

_____ _____
(cell) (home)

Address:

_____
(street)

_____
(city) (state) (zip code)

Height_____ Weight_____

Eye Color_____ Hair Color_____

How would you describe yourself?

_____

What do you do together in your leisure time?_____

What do you do separately in your leisure time?

_____

Describe your support system (who you talk to, lean on, spend time with).

_____

_____

Partner

Name _____

Date of Birth_____ Age____

_____ _____ (home)
(cell)

Address (if different):

_____
(street)

_____
(city) (state) (zip code)

Height_____ Weight_____

Eye Color_____ Hair Color_____

How would you describe yourself?

_____

What do you do separately in your leisure time?

_____

_____

_____

Patient **Partner**

Who have you told and not told about the procedure(s) you will be trying?

_____ _____

_____ _____

In what helpful ways do you handle your stress?

_____ _____

How much alcohol do you currently use?

_____ _____

Do you use any non-prescribed drugs? If so, which?

_____ _____

Are you currently involved in any lawsuits or have any legal concerns?

_____ _____

What, if any, are your religious or spiritual affiliations?

_____ _____

In what way might these have an impact on your decisions about your procedures?

_____ _____

_____ _____

_____ _____

Place of Employment_____ Place of Employment_____

Occupation_____ Occupation_____

How many years? _____ How many years?_____
Colleges Attended: Colleges Attended:

_____ _____
(Name) (Degree) (Name) (Degree)

Both

Marital Status (check one):
____single ____married __living together How long married/living together?_____

How long dated before marriage?_____ Have either of you been married before?____

If yes, who?_____ For how long?_____

Patient (or recipient)	**Partner**
Ages and Genders of Siblings	Ages and Genders of Siblings
_____	_____
_____	_____
Where were you born and raised?	Where were you born and raised?
_____	_____
Current Medical Conditions	Current Medical Conditions
_____	_____
Current Prescription Medications	Current Prescription Medications
_____	_____

Name of Reproductive Endocrinologist_____

Diagnosis_____

Medications Prescribed for A.R.T._____

Assisted Reproductive Technology Treatments with Dates & Results of Procedures:

_____

Upcoming Procedures scheduled with dates_____

Dates of Previous Pregnancies_____

Names and Ages of Children, if any_____

Name of Primary Care Physician(s)_____

Patient **Partner**

What are your thoughts and criteria for selecting a donor/surrogate (if applicable)?

_____ _____

_____ _____

What are your thoughts about whether to inform a child born of a donation/surrogate procedure about its genetic origins or gestation?

_____ _____

_____ _____

Please list any other issues that might be important to discuss as you move forward with assisted reproductive technology.

_____ _____

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DISCLOSURE INFORMATION & PSYCHOLOGICAL SERVICES AGREEMENT FOR INTENDED PARENTS

This document (agreement) contains important information regarding psychological evaluation and consultation services that will help establish your eligibility in a third-party reproductive agreement. This document includes client rights throughout this process, as well as outlines business policies and expectations for services rendered through my practice. Please read this document carefully before we meet in person. We can discuss any questions that might arise about the following policies and procedures at that time. Please be aware that when you sign this document, it will represent an agreement between us.

Service Provider:

Emily Fogle, Psy.D.
Psychologist
Georgia License # PSY003765

Education/Degrees:
Doctor of Psychology (Psy.D.) in Clinical Psychology - University of Denver, 2012
Master of Arts (M.A.) in Clinical Psychology - University of Denver, 2009
Bachelor of Science (B.S.) in Psychology - University of Georgia, 2005

Client Rights and Ethical Conduct in the Practice of Psychology:
The practice of licensed or registered persons in the field of psychology is regulated by the Georgia Board of Examiners of Psychologists. The Georgia Board of Examiners of Psychologists can be reached at 237 Coliseum Drive, Macon, Georgia 31217-3858, (478) 207-2440.

You are entitled to receive information about the methods of psychological evaluation/consultation, the techniques used, the duration of the evaluation/consultation, and the fee structure. Please ask if you would like to receive this information.

You can seek a second opinion from another provider or terminate the evaluation/consultation at any time.

In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

Confidentiality between psychologist and client is guaranteed by Georgia law except under certain circumstances. For example, psychologists are required to report suspected child abuse, elder abuse, and homicidal or suicidal threats or intentions.

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice of my Privacy Policies and Practices. Please read and sign the included HIPAA notice that lists these rights in greater detail.

Meeting(s) and Procedures:
There are many ways that families are made today. Egg donation, various forms of adoption, sperm donation, surrogacy, traditional conception, and stepfamilies are the most common ones. Almost all children have issues that come up during their life that are unique to their families or to them. Your consultation will help you understand your future child's uniqueness and the issues that he or she might experience. The main goal of psychological consultation is to help you think through your choices, gain a deeper understanding of the issues and make choices that will help your family be healthy and happy. Examples of issues we might discuss include:

- A brief review of your infertility history.
- Brief histories of each individual and your relationship.
- Your level of comfort with your choice to pursue gamete donation.
- Your individual strategies for managing stressful times in your lives.
- Similarities and differences that your child may have with children that come from gamete donation, surrogacy, the traditional family unit, adoption, and step-families.
- Reasons to consider why you may want to (or not want to) tell your child about his or her genetic origins. Every couple is different, bringing unique and important issues that impact the choice that is best for them. If you plan to tell your child, we will discuss choices about when and how to provide the information and how they may respond.

Discussing this information will better prepare you for the process you are about to undergo and for the issues that might arise in your relationship and in your future family as a result of this process. I encourage you to ask any questions that come to mind. Some couples like to bring a list of questions or a pad of paper for taking notes. After your consultation, I will send a brief report to your referring doctor. The report is confidential and contains basic summary information and recommendations. The report will remain in your medical file.

It is important to understand that the aforementioned services may change due to circumstances that may arise during the course of your evaluation and/or consultation. By signing this agreement you also understand and agree that:

1) For any number of reasons you might not be approved to participate in a third-party reproductive agreement. In the likelihood you are not approved you release me from any liability related to my opinion and findings of my evaluation.
2) Additional counseling may or may not be required or provided to grant you eligibility for a third-party reproductive agreement, following the completion of your consultation/evaluation. You agree that if you are asked to participate in additional counseling you will do so.
3) There may be psychological risks associated with your participation in the proposed fertility treatments, including those that might arise during counseling or evaluation. The risk of psychological harm occurring in each individual circumstance cannot always be accurately predicted. Provided I have acted reasonably and with the pertinent professional standards and guidelines, you release me from claims of liability related to any psychological harm that you may suffer as a result of your participation in counseling or evaluation, or related to my participation in the proposed treatment, and accept the risks of psychological harm.
4) If I am to be retained as the evaluator/consultant for an egg donor or surrogate candidate in the third-party reproductive agreement, you understand that I maintain a professional responsibility to each client individually and separate from the interests of the other party. I may advise against the participation of your donor or surrogate, or render other advice that will impact the proposed treatment. Provided I have acted reasonably with the professional standards and guidelines and any applicable laws governing the practice, you release me from

liability with regard to claims of conflict of interest. If you believe this scope or representation is unacceptable, you may request evaluation from another provider who is qualified. You maintain an independent right to pursue a claim of negligence or malpractice, notwithstanding the above.

Financial Agreement:
My consultation fee is $1,350.00. This fee includes face-to-face time as well as report writing and consultation with physicians. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation costs, even if I am called to testify by another party.

Billing and Payments:
My practice accepts cash, checks, and credit cards. Clients will be responsible for payment at the time services are rendered. Checks that are returned will be assessed a $30.00 returned check fee to cover bank costs.

You will be expected to pay for the cost of the evaluation and consultation services at the time these are held, unless we agree otherwise. Payment schedules for other professional services will be agreed to at the time when these services are requested.

If your account has not been paid for more than 60 days and suitable arrangements for payment have not been agreed upon, I have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, the costs of bringing that proceeding will be included in the claim.

Cancellation Policy:
In the event you need to cancel an appointment, **please provide notice within 24 hours of your scheduled appointment time**. If sufficient notice of a cancellation is not provided, or no notice is given at all, the standard service fee as agreed upon in this disclosure will be assessed for that session. No charge will be made for appointments missed due to true emergencies. By their nature, emergencies do not occur frequently; if such cancellations arise frequently in the course of treatment, this would require further discussion between us.

Contacting Me:
Due to my work schedule, I am often not immediately available by telephone. While I am typically working between 9am and 5pm, I will not usually answer the phone when I am meeting with a client. My telephone is answered by a confidential voicemail system that alerts me to all calls. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please leave a message with the best times when you will be available. If I am unavailable for an extended time, I will provide you with the name of a trusted colleague whom you can contact, if necessary. If you cannot reach me, and you feel that you cannot wait for me to return your call, you should call you family physician or the emergency room at the nearest hospital and ask for the psychologist or psychiatrist on call.

Should we agree to terminate services at any point during the consultation and/or evaluation services, I will no longer be responsible for responding to any clinical emergencies, unless we have mutually agreed to re-engage in consultation. I am not responsible for any emergencies after the termination of your consultation and/or evaluation. The state of Georgia requires me to maintain records for seven years following the completion or termination of services, at which time these records will be destroyed in a manner that protects your confidentiality.

Communication and Confidentiality:
Please note that cellular telephone and e-mail communications are vulnerable to breeches of confidentiality due to their modes of information transmission. I do communicate with patients via email and cellular telephone. Your preference noted and signature at the end of this document indicates permission and understanding of the following communication methods used in this therapeutic relationship:

Email communications: ____ ____ **Address preferred:**_____
YES **NO**

Phone communications: ____ ____ **Number preferred:**_____
YES **NO**

Confidentiality:
The law protects the privacy of all communications between a client and a psychologist. In most situations, I can only release information about your treatment to others after you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require that you provide written, advance consent. Your signature on this agreement provides consent for those activities, as follows:

- If a client threatens to harm herself/himself, I may be obligated to seek hospitalization or her/him or to contact family members or other parties who can ensure safety.
- I may occasionally find it helpful to consult with other health and mental health professionals about a case. In these consultations, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. Unless you object, I will not tell you about these consultations unless I feel it is important to our work together. I will document all consultations in your Clinical Record.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am permitted or required to disclose information without your consent or obtaining previous Authorization:

- If you are involved in a court proceeding and a request is made for information concerning my professional services (e.g., subpoena or subpoena duces tecum), such information is protected by the psychologist-client privilege law. You have the right to file a motion with the court to quash any subpoena. I will not provide any information to your counsel or other legal party without your written authorization; however, if a court order is issued to me, I have to release the information requested by that order. I will make an effort to notify you in that case, but your authorization is not required. If you are involved in or contemplating litigation, you should always consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- If a client files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills.

There are some situations in which I am legally required to take actions when I believe that they are necessary to protect others from harm. In these situations, I may have to reveal some information about a client's treatment:

- If I have reasonable cause to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Human Resources. Once such a report is filed, I may be required to provide additional information.
- If I have reasonable cause to believe an elder person or a disabled adult has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report to an agency designated by the Department of Human Resources. Once such a report is filed, I may be required to provide additional information.
- If I determine that a client presents a serious danger of violence to themselves or another person, or they are gravely disabled to the extent they no longer provider for their own well-being and safety, I may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the client.

If such a situation arises, I will make every effort to fully discuss these circumstances with you before taking any action and I will limit my disclosures to third parties only to the effect necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important we discuss any questions or concerns that you may have now or in the future. The laws governing these issues are quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Insurance Reimbursement:
Because I am a licensed psychologist, many health insurance plans will help you pay for consultation and evaluation services offered through my practice. However, please note that I am not on managed care/insurance panels. I provide an invoice for office visits with the information needed to submit to your insurance company's "out of network" providers. Because health insurance is written by different companies, I cannot tell you what your plan covers. I will provide you with whatever assistance I can in facilitating your receipt of the benefits to which you are entitled, including filling out forms, as appropriate. However, you, and not your insurance company, are responsible for full payment of the fee to which we have agreed. It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions, you should call your plan administrator.

You should be aware that most insurance agreements require you to authorize me to provide them with information relevant to the services you received. I am required to provide a clinical diagnosis, and sometimes additional clinical information such as a treatment plan or summary, or copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be computerized. All insurance companies claim to keep such information confidential, but I have no control over what they do with it, once it is in their hands. In some cases they may share your information with a national medical information data bank. If you request it, I will provide you with a copy of any report that I submit. By signing this agreement, you agree that I can provide requested information to your insurance carrier. It is important to remember that you always have the option to pay for my services yourself and avoid the complexities described above.

Additional Information
Dr. Emily Fogle is practicing as an independent practitioner. Please be aware that other than using office space at Atlanta Women's Healthcare Specialists on some occasions, there is no other business relationship between Dr. Fogle and other treatment providers in the office suite. Dr. Fogle and Atlanta Women's Healthcare Specialists bill separately. Even though physical space is shared, there is not shared liability across providers. Other providers will not have access to your information without your signed release of information.

Client's Statement of Understanding and Agreement

I, _____, agree to participate in all procedures in an honest and thorough fashion. I understand that the findings and the report will be sent directly to the appropriate staff at the Atlanta Center for Reproductive Medicine. I waive all rights to the material.

Your signature below indicates that you have read this agreement, agree to its terms, and understand your rights as a client.

By this signature, you also hereby acknowledge that you have received a copy of the HIPAA "Notice of Privacy Practices."

_____
Print Client's name

_____ _____
Client's Signature Date

_____ _____
Emily Fogle, Psy.D. Date

Emily Fogle, Psy.D.

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AUTHORIZATION TO RELEASE INFORMATION

Pursuant to 45 CFR 164.508 and the Health Insurance Portability and Accountability Act,

I,_____, hereby authorize Emily Fogle, Psy.D. to **exchange** relevant information about treatment or the protected health information (PHI) with the following parties. This information includes written and verbal transfer of history, as well as mental health diagnosis and treatment information for the purposes of consultation and coordination with relevant professionals.

This information should only be released to my physician _____, his or her nurse(s), and appropriate staff.

This authorization shall remain in effect until I am no longer a patient of _____ or until such time as I revoke this authorization.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that Dr. Fogle generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient Date

_____ _____

_____ _____
Emily Fogle, Psy.D. Date

I am **revoking** consent and authorization to request or release information.

_____ _____ _____
Signature Printed Name Date

Emily Fogle, Psy.D.

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GEORGIA NOTICE FORM

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

• "PHI" refers to information in your health record that could identify you.

• "Treatment, Payment and Health Care Operations"

– Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

– Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

– Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

• "Use" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

• "Disclosure" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization (already released the information according to the authorization); or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse – If I have reasonable cause to know or suspect that a child has been subjected to abuse or neglect, I must immediately report this to the appropriate authorities.

- Adult and Domestic Abuse – If I have reasonable cause to believe that an at-risk adult has been mistreated, self-neglected, or financially exploited and is at imminent risk of mistreatment, self-neglect, or financial exploitation, then I must report this belief to the appropriate authorities.

- Health Oversight Activities – If I am the subject of an inquiry by the Georgia Board of Psychological Examiners, I may be required to disclose PHI regarding you in proceedings before the Board.

- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privileged does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- Serious Threat to Health or Safety – If I determine, or pursuant to the standards of my profession should determine, that you present an imminent and serious danger to yourself or someone else, I may disclose such information in order to provide protection against such danger for you or any other intended victim.

- Worker's Compensation – I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provided benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information regarding you. However, I am not required to agree to a restriction you request.

- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

• Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

• Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

• Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

• I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

• I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

• If I revise my policies and procedures, I will notify you by mail or in person. Additionally, a requested revised notice of policies and procedures can be sent to the requester by mail.

V. Questions or Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me (Emily Fogle, Psy.D.) directly at (770) 376-7764.

If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written complaint to me (Emily Fogle, Psy.D.), at 275 Collier Road, Suite 100-A, Atlanta, GA 30309. You may also send a written complaint to the Secretary of the Department of Health and Human Services, at 200 Independence Avenue S.W., Washington, D.C. 20201.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on January 29, 2014.

I reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI that I maintain. If you are an active client, I will provide you with a revised notice at your next session following the revision.

HOW TO WORK WITH YOUR INSURANCE COMPANY

Dr. Fogle is not affiliated with any PPOs or HMOs and does not file insurance. However, she is happy to help guide you through complicated filing procedures and to assist you with your filing claims. If you ask the right questions and follow the right procedures, you can maximize the reimbursement that you will receive. It is always helpful to call your insurance company before your initial appointment so that you can know more about your coverage. The following is a useful guide to asking the right questions.

1. Call the MEMBER SERVICES phone number on your insurance card. If your insurance company has a separate phone number for MENTAL HEALTH or BEHAVIORAL HEALTH, call that instead.

2. Ask to speak with a representative (live person).

3. Tell the representative that you would like information about OUTPATIENT MENTAL HEALTH benefits or BEHAVIORAL HEALTH benefits.

4. Ask how you would find out whether Dr. Fogle is a “preferred” or “in-network” provider.

5. Ask the representative to explain your “in-network” benefits AND your “out-of-network” benefits.

6. Be sure to ask about:

Deductibles (how much you have to pay before the insurance company will begin paying),
Co-pays (how much you will need to pay for each session),
Fee caps (some companies will only pay out up to a certain dollar amount whether or not that comes close to the “going rate”).
Session limits (some insurance companies limit the number of sessions they will cover per year).
Claims address (be sure to ask for the address where claims must be sent in order to get reimbursement).
Preauthorization requirements (ask whether preauthorization is required For outpatient mental health and what the process is for obtaining this. Also, are treatment plans necessary for continued treatment?).
Forms (what forms are required for filing and how can you obtain them?).

INSURANCE PROCEDURES CAN BE VERY CONFUSING. HOWEVER, IF YOU ASK THE RIGHT QUESTIONS AND FOLLOW THE RIGHT STEPS, YOU CAN GET YOUR APPROPRIATE REIMBURSEMENT.