Dennis McCarthy, MA LMHC
Psychotherapist
Washington State Licensed Mental Health Counselor #LH60086698
Tax ID #20-8418136
National Provider Identifier #1215147145

1904 3rd Avenue, Suite 915, Seattle, Washington 98101
206.595.2659
dennis@unstuckseattle.com
www.unstuckseattle.com

Insurance Agreement

Client Name: _____ Date of Birth: _____

Information for Insured Person (if Different From Client)

Name of Insured: _____ Date of Birth: _____

Address: _____

Phone: _____ (is this Cell? ___ Home? ___ Work? ____)

Insurance Information

Insurance Company: _____ Phone: _____

Member ID: _____ Group: _____

Claims Address: _____

Plan Information

Does the plan cover mental health office visits? Yes _____ No _____

Is preauthorization required? Yes _____ No _____

Are there any limits on the number of sessions? Yes _____ No _____

What are out of pocket expenses per visit (copayment, coinsurance)? _____

Is there an annual deductible? If so, how much is it? _____

Does the annual deductible apply to mental health office visits? Yes _____ No _____

Client Responsibility Statement

- I understand that my portion of the fee is due at time of service.
- I understand that a no show fee will be charged for appointments cancelled without 24 hours notice. Because insurance does not pay for missed sessions, I will be responsible for the full fee, not just the co-pay.
- I understand that I am responsible for paying my deductible and any amounts not covered by insurance.
- I understand that if, for any reason, my insurance company does not pay my fee, I am responsible for the entire amount.

I authorize the release of information needed to verify and process insurance claims to Dennis McCarthy, MA, LMHC.

Client's name (please print): _____

Signature: _____ Date: _____/_____/_____

Signed by: __client __guardian* __personal representative

* By signing a guardian attests to the fact that he or she has the legal right to sign on behalf of client.