Julie Cast, LMFT
Billing Information

This form is required for all patients regardless of insurance coverage status

Patient Name:	DOB:	**Gender** (according to insurance documents) □ **Male** □ **Female**
Address:		
City:	State:	Zip:
Phone #: □ Cell □ Work □ Home/Landline		Preferred method of contact: □ **Text (SMS)** □ **Email** (If neither is indicated, we will use secure email)
Alternate Phone #: □ Cell □ Work □ Home/Landline		
Email:		

□ **Initial here if you have no insurance coverage OR you do not want your insurance billed.**

Do you have coverage with any of the following? (Check all that apply)
(Please attach an additional copy of this page to share information about all other insurance coverages)
EAP □ **Medicaid (OHP)** □ **Medicare** □ **Other Insurance** □

Insurance Company: _____ Phone: _____
This policy is (check one)**:** □ **Primary** □ **Secondary**

Primary Insured Name & DOB: _____ DOB: _____

Relationship to Patient: _____ Employer: _____

ID#: _____ Group # _____
This policy is (Check one): □ Health Insurance □ EAP □ Worker's Compensation □ Auto Insurance □ Other

Address: _____

***** PLEASE ATTACH A COPY OF THE FRONT AND BACK OF ALL INSURANCE CARD(S) *****

I have been given an opportunity to read the Billing Disclosure (attached), and I hereby authorize the provider named above, and appointed billing agent(s) to provide summary of care and assessment information regarding evaluation and/or treatment of the patient named above for the purpose of evaluating and processing claims for benefits. **I have completed this form correctly and completely to the best of my knowledge, disclosing all payer(s) that cover me. I understand that providing incorrect or incomplete information on this form may result in a higher than expected out of pocket expense for me. I will contact the billing office if any of the information reported on this form changes.**

Signed: _____ Date: _____
Relationship: **Self** □ Other (Print Name) _____ (Relationship) _____
Please return completed form to the billing office: info@professional-practice.org or Fax (503)419-4662.

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Billing Information

Billing Information Disclosure

Thank you for completing your billing information form and attaching a copy of the front and back of your insurance card(s). Please review the information below to be familiar with the billing process. We would like to keep your out-of-pocket expense as low as possible, and we need your cooperation to make that happen.

ꕥ The billing information form is necessary for all patients, whether you are covered by insurance or not. If you have insurance, be sure to fill in your ID# and Group # on the billing information form **and also** send a copy of your insurance ID card. Completing this form improperly may result in an inaccurate estimate and greater than expected out-of-pocket expense for you.

ꕥ **Good Faith Price Estimate.** The billing office will reach out to you with a good faith price estimate for routine services by secure email (to the email address that you fill in on the billing information form attached) or text message within three business days of receiving your completed billing information form and a copy of your insurance card(s). If you have not received a good faith estimate within three days of sending your completed forms, please contact our office directly **(email: info@professional-practice.org / Phone (541)234-4781)**. **Please note that this is a good faith estimate based on information provided by you and your insurance company, not a guarantee of payment. Final benefit determination will be made by your insurance company after they have received your claim.** We encourage you to contact your insurance company verify your benefits and the terms of your plan. The billing office can provide you with a Patient Price Estimate Worksheet for gathering information to verify your benefits. In some cases, a Patient Price Estimate Worksheet completed before services were rendered can support an appeal if your insurance processes claims differently than they said they would.

ꕥ **Carve-Out Plans.** Occasionally, insurance plans will carve out mental health benefits to another company. (In other words, you may have medical insurance with one company, but your mental health claims may be processed by another company.) We can find out about situations like this during the price estimate. If your mental health benefits are carved out to a company that your provider is out of network with, you may have a higher than expected out of pocket expense for treatment. Please be sure to return your insurance information form to the billing office at least 10 business days before your first session so that you have the opportunity to review your estimate before services are rendered.

ꕥ **Changes**. **Please contact our office immediately if anything reported on the Billing Information form changes.** In some cases, a change of your information will change your out-of-pocket expense for treatment, even if the type of treatment that you are receiving doesn't change. We may not be able to bill your insurance or warn you of increased out-of-pocket expense if we don't have current information at least 10 days before changes become effective.

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Billing Information

EAP Benefits. If you have Employee Assistance Plan (EAP) benefits, your EAP may be managed by a different company than your medical insurance. If you would like to use your EAP benefits, please contact your EAP to make sure that the provider you are seeking treatment with is in your EAP network. Most EAP plans will not pay for services with an out-of-network provider. We cannot bill your EAP if we don't have your EAP authorization information in writing from your EAP administrator prior to treatment. If you want us to bill your EAP, please send a copy of your EAP authorization letter/email to our office with your Billing Information form so that we can bill your EAP. In some cases, we may not be able to bill EAP plans retroactively, so it is especially important that you send a copy of your EAP authorization with your Billing Information form to ensure that your EAP can be billed. If you fill out your billing information form with your medical insurance information, your medical insurance will be billed, and your EAP benefits will not be applied.

Dual Coverage. If you are covered by more than one insurance plan, please attach additional copies of the Billing Information form completed with your other insurance information and a copy of the front and back of all insurance cards for all plans and policies that cover you. **Please include this information even if you don't think that your other insurance will cover the treatment you're seeking.**
If your insurance denies your claim because they think that another payer should be billed first (also known as 'Coordination of Benefits' (COB)), we will send you a statement for the balance due, noting that your insurance refused to pay, indicating that you have another coverage that should be billed first. In that event, you would need to contact your insurance company and provide the information that they need in order for your claim(s) to be reprocessed and then contact us to follow up so that your claims can be resubmitted. If we don't hear from you within 30 days of your statement to indicate that you provided the information required by your insurance company and we don't receive updated insurance information from you before the deadline established by your primary insurance company for timely filing, you may be liable for the entire balance of the claim, as established in ORS 410-120-1280(5).

If you have any questions, please contact the billing office:

Phone (541)234-4781 / Email: info@professional-practice.org / Fax (503)419-4662
Mail: PO Box 503010, White City, OR 97503-0813
Patient Portal: https://portal.kareo.com/app/new/login

Thank you.

Professional Practice

Julie Cast, LMFT
Fee Agreement

Patient **Name:**	**Patient** **DOB:**
Guarantor Name:	Relationship of Guarantor to Patient: □Self □ Other: _____
Guarantor Mailing Address:	Phone:
Guarantor Email:	

Guarantor: a person responsible for account payment. The patient and guarantor may or may not be the same person.

The standard fee at Julie Cast, LMFT (my Provider), is $78.75-$125 per routine session for outpatient mental health counseling. My treatment may include any of the codes and services listed on this form (page 2) depending on my treatment plan.
My signature below indicates that I am financially responsible for the patient account identified above according to the terms of this agreement below.

Guarantor Signature	**Date**

- ✓ I am prepared to pay my estimated balance to my Provider prior to each session, as well as all fees not covered by insurance.
- ✓ I understand that if my copay, coinsurance, or other balance and associated fees are not paid within 30 days of being invoiced, or I provide incomplete or inaccurate billing information, a $9 billing fee may be assessed.
- ✓ I understand that my healthcare coverage is between me and my insurance company. I will be ultimately responsible to know the terms and exclusions in my plan, and to ensure my payer's cooperation with my Provider's office. If no insurance payment has been received by my Provider within 60 days of billing, I will be responsible to pay the unpaid balance on my account. I will be promptly reimbursed if my Provider subsequently receives payment.

Professional Practice Medical Billing - rev 12/14/2021
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Julie Cast, LMFT
Fee Agreement

- ✓ I understand I will be responsible for paying a **fee for missed appointments** when 24-hour prior notice is not given (No Show*), and my insurance company will not be billed.
- ✓ If my insurance policy or another third-party coverage denies my claim, I may be responsible for paying the Standard Fee unless prohibited by law.
- ✓ My Provider has a legal right to utilize a collection or billing service to collect payment from me if I fail to pay in full for services received, and to refuse services until such payment is made. ***My Provider has the right to impose additional fees of up to 50% if my account is referred for collections.***

Standard Fees (Patient out-of-pocket expense if not covered by insurance)

CPT Code	Brief Description	Fee
90791	Initial Session (Diagnostic Evaluation)	$125
90832	Psychotherapy – 30 minutes	$78.75
90834	Psychotherapy – 45 minutes	$125
90837	Psychotherapy – 60 minutes	$125
90847	Family Psychotherapy (patient present)	$125

☑ No other costs are anticipated as part of this treatment.

I will contact the billing office with the information below if I need to do any of the following:

- ✓ Provide updated information
- ✓ Cancel or rescind this fee agreement
- ✓ Ask questions or voice concerns
- ✓ Arrange for payment of my balance
- ✓ Apply for a discount or payment plan due to financial hardship

Professional Practice ▪ Phone (541)234-4781 •Email: info@professional-practice.org
Mail: PO Box 503010, White City, OR 97503

Rev 07/30/2021

Julie Cast, LMFT
PO Box 503010, White City, OR 97503-0813
Phone: (541)234-4781 / billing@professional-practice.org

Credit Card Authorization

Please complete this form to authorize the office named above to charge your credit card for your balance.

Name as it Appears on Credit Card

Address (including city, state, and zip code) as it appears on Credit Card Statement

---

Patient Name

Credit Card # _____Expiration Date: _____Auth Code _____

Type **(Circle One)**: Visa Master Card American Express Discover

<u>Unless an option is completed and initialed below,</u> I am authorizing my provider's office to charge the above credit card after session(s) for the balance due on my account per my insurance company's determination or per my fee agreement with the provider in the absence of insurance determination until my credit card expiration date above.

Cardholder Signature Date

OPTIONS: To amend the above bolded statement, complete and initial an option below:

____ **SINGLE** • I authorize a single charge of $ _____ to be charged on _____ (date).

____ **INSTALLMENT PLAN** • I authorize an installment plan of $ _____ per (□ Month or □ Week) starting _____ (date) for # _____ installments, totaling $ _____.

____ **FLEXIBLE INSTALLMENTS** • I authorize a recurring charge of up to $_____ (my estimated copay/coinsurance, per session).

____ **OTHER** • I attached details of my authorization to charge my card (subject to Provider approval).

Julie Cast, LMFT

Authorization to Release Protected Information

Patient Name:	**DOB:**

This form is optional. I authorize my Provider indicated above (and appointed staff and billing agent) to use and disclose specific health information described below (according to ORS 192.559) to:

Name:	Phone:
Mailing Address:	
Email:	

Specific information to be released: □ Clinical Information □ Financial & Accounting Information

□ Other: _____

Purpose of Release: Coordination of Billing (and Other *(if applicable)*: _____)

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS information
_____ Mental health information
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization, or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization, please send a written statement to Tracy Gonzalez / Professional Practice, LLC at PO Box 503010, White City, OR 97503-0813 or by fax to (503)419-4662 or by email to info@professional-practice.org . State your name, the patient's name, the patient's date of birth, and state that you are revoking this authorization to release information.

I have read this authorization and I understand it. This authorization expires at the conclusion of treatment unless another date or event is described below.

_____

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: □ Self □ Other: _____

Rev 12/21/21 TG-PPL

Patient Price Estimate Worksheet

Professional Practice, LLC – Full Service Medical Billing
PO Box 503010, White City, OR 97503-0813
Phone (541)234-4781 / info@professional-practice.org

Our office will provide with you with a Good Faith Estimate of your benefits (per 45 CFR 149.610). The benefits estimate that we send you is not a guarantee and is based on the information we receive from your insurance company. We strongly encourage you to also take this opportunity to contact your insurance company to find out what your insurance will cover for the services that you are seeking.

- You can use your insurance company's online member center tool. This tool varies by region and by company. You can call the phone number on the back of your insurance card for assistance with this tool.
- **OR**: You can call the phone number on the back of your insurance card. The tollfree number for "Member Services" or "Customer Service" will likely be the most direct number.
    - Follow the prompts to speak with Customer Service.
    - Tell the representative you speak with in Customer Service that you would like to find out what your benefits are for services with your provider or clinic.

The following 5-minute YouTube clip explains some useful basics about how your policy works:
https://www.youtube.com/watch?v=DBTmNm8D-84

Provider / Practice Name:	
Provider NPI# (National Provider ID #)	
Provider Type (Circle One)	Psychiatrist / Psychologist / Psychotherapist / Other: _____
Date / Time of Call	
Phone Number Called	
Representative's Name	
Call Reference Number	
Is the provider in network or out of network?	In Network / Out of Network
Do I have a deductible [1] ?	Yes / No
Does my deductible apply to outpatient mental health services?	Yes / No
Does my deductible apply to Outpatient Mental Health treatment? (Codes listed below per provider type)	Yes / No
PSYCHIATRIST. Codes which may be billed for **standard psychotherapy and medication management with a PSYCHIATRIST (MD, DO, PMHNP):**	

CPT 99205 – Intake Session CPT 90792 – Intake Session CPT 99214 + 90836 – Office Visit + Psychotherapy 60 Min CPT 99214 + 90833 – Office Visit + Psychotherapy 30 Min CPT 90837 - Psychotherapy 60 Minutes	
PSYCHOTHERAPIST. Codes which may be billed for **standard psychotherapy with a PSYCHOTHERAPIST (LPC, LCSW, LMFT, MFT):** 90791 – Intake Session 90834 – Psychotherapy 45 Minutes 90837 – Psychotherapy 60 Minutes 90846 – Family therapy (patient not present) 90847 – Family therapy (patient present) 90853 – Group psychotherapy	
PSYCHOLOGIST. Codes which may be billed for **psychological testing with a psychologist (PhD, PsyD):** 90791 – Intake Session 90837 – Follow Up Session 60 Minutes 90834 – Follow Up Session 45 Minutes 96130 – Psychological Testing 60 Minutes +96131 – Psychological Testing – additional 60 Minutes 96132 – Neurocognitive Testing +96133 – Neurocognitive Testing – additional 60 Minutes 96136 – Psychological Testing 30 Minutes +96137 – Psychological Testing – additional 30 Minutes	
Does my plan cover telehealth services? Does my plan exclude telehealth services? [3] Is my coverage for telehealth the same as my coverage for in-person (face-to-face) sessions?	Yes / No Yes / No Yes / No
How much of my deductible has been met, and how much remains to be met?	Met: $ _____ Remaining: $
When (what date) does my deductible renew?	
Do funds applied to my deductible in the last quarter of the plan year apply to my deductible the following year?	Yes / No

° PO Box 503010, White City, OR 97503-0813 °Phone (541)234-4781 ° Fax (503)419-4662 °
° Email info@professional-practice.org ° Website professionalpractice.net °

Do I have a separate family deductible?	Yes / No
… if so, how much has been met, and how much remains?	Met: $ _____ Remaining: $
<u>What are my benefits after my deductible is met?</u> Do I have a copay (set dollar amount that I will have to pay per session? Do I have a coinsurance (a percentage of the allowed rate that I will have to pay per session)? Do these benefits vary depending on the type of service (reference listed CPT codes above according to the provider type that you are seeking treatment with)?	
Do I have an out-of-pocket maximum (aka: stop-loss)? [2]	Yes / No
How much is my out-of-pocket maximum, and how much is remaining?	Met: $ _____ Remaining: $
Can you give me a quote of my out-of-pocket expense for this treatment in writing?	

1. Deductible: The amount you pay out of pocket for covered health care services before your insurance plan starts to pay
2. Out of pocket max is the maximum amount that you would have to pay out of pocket for healthcare in the plan year before your insurance begins paying 100% of charges for in network providers.)
3. Telehealth: Telehealth is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage your health care. (https://www.mayoclinic.org/healthy-lifestyle/consumer-health/in-depth/telehealth/art-20044878)

Some of the questions on this worksheet may seem redundant but asking all of them is important because discrepant answers to seemingly redundant questions help to uncover important information.

Feel free to send a copy of your completed worksheet to the billing office for your file. In some cases, your Patient Price Estimate Worksheet may be useful in appealing claim(s) with your insurance company in the event that your insurance company pays less than expected.

Billing Office Phone: (541)234-4781
Billing Office Fax: (503)419-4662
Billing Office Email: info@professional-practice.org
Billing Office Mailing Address: PO Box 503010, White City, OR 97503-0813