Office: 13121 Co Rd 16, Blair, NE 68008
Phone: 402.426.9020
Website: www.upperoomcounseling.com

ASSIGNMENT OF BENEFITS AGREEMENT

Upper Room Counseling will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your mental health benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

Although we will complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment. ***Please initial x*****_____**

We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office. *Pl**ease initial x*****_____**

We require you to pay the co-payment, which is the amount not covered by your insurance company. You either pay that amount at the time of service or you will be sent a bill for the amount owed.
Please initial x**_____**

Our office does not guarantee that your insurance company will pay for the service you receive from our office. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
Please initial x**_____**

Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company. ***Please initial x*****_____**

We require you to reschedule your appointment no later than 24 hours prior to the appointment. You may be subject to charges for missed appointments. Please discuss with your individual therapist.
Please initial x**_____**

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY MENTAL HEALTH BENEFITS DIRECTLY TO I have read and understand the above terms and conditions. I authorize my insurance company to pay my mental health benefits directly to Upper Room Counseling and my therapist.
Signature of Patient/Responsible Party_____________________________
Date____________________