HOW CAN I FIND OUT WHAT MY INSURANCE PLAN WILL COVER AND WHAT MAY BE OUT OF POCKET COSTS TO ME?

You can find out by contacting your insurance carrier, using the form below as your guide to determine the terms of coverage for your visits with Dr. Mary Freitag. Complete the form below and bring it to your first appointment.

Patient Name: _____ DOB: _____

Insurance Company: _____

ID #: _____ Group #: _____

Dr. Mary Freitag is: ○ IN-NETWORK ○ EXTENDED NETWORK ○ OUT OF NETWORK

Do you have a deductible? Individual: $_____, Family $_____.

Is this per calendar year or plan year? _____

Do you have co-insurance (list percentage you owe after insurance pays a portion): _____%
(Example: Insurance will cover at 80% or 60% of the allowed/usual and customary amount, you would then owe 20% or 40% as an example of the remaining allowed/usual and customary amount, respectfully.)

Do you have a copay for each visit? $_____ due each visit.

If out-of-network, I understand that I will additionally owe the difference between the charged or "billed" amount and the "allowed amount" (usual and customary).

Do you have an Out of Pocket Maximum Per Year? Individual: $_____, Family $_____.

Is authorization or a referral required? _____

Is there any visit limit for services? _____

❑ A. I obtained this information from my insurance card or I know the details of my benefits.

❑ B. I obtained this information by calling my insurance company and speaking with _____ on _____ (date/time) at insurance company.

_____ (initial here) I understand that Late Cancels or Missed Appointments will be charged to me at the rate of the scheduled appointment.

_____ (initial here) I understand Late Cancels or Missed Appointments is uncollectible by insurance and will be my responsibility to pay at my next visit.

_____ (initial here) I understand my financial responsibility and agree to pay my portion as indicated by my insurance company in a timely manner.

_____ (initial here) I agree, when or if my insurance or any contact information changes, I will update my information with both Dr. Mary Freitag and their business office, Professional Services Consultants, LLC *within a timely fashion (within 30 days)* so that charges for my visits can be billed correctly.

_____

Signature Date

_____

Print Responsible Payee Name Above