



INSURANCE BILLING ENROLLMENT PACKET

REQUIREMENTS TO UNDERSTAND AND DECISIONS TO MAKE BEFORE ENROLLING FOR SERVICES WITH CONNIE BONNER-BRITT, MA, LMHC.

Since Connie does not have staff to do things like check your insurance, send out monthly billings or deal with collection agencies and since she wants to continue charging much lower than average fees... she needs you to understand her payment rules very clearly BEFORE you make a decision to schedule your first session:

1. YOUR CREDIT CARD INFORMATION AND YOUR AUTHORIZING SIGNATURE MUST BE ON FILE PRIOR TO SCHEDULING THE FIRST SESSION.

NOTE: You can sign up for [PayPal BillMeLater](#) and get six months to pay without interest.

2. PLEASE CHOOSE BETWEEN 2a OR 2b BELOW

2a.	DISCOUNTED (NO INSURANCE) RATES	2b.	INSURANCE BILLING RATES
	<p>Fees for service with no insurance billing:</p> <ul style="list-style-type: none"> • INTAKE: \$110.00 • REGULAR SESSIONS: \$75.00. • If you need a reduced fee please call me now at: 360-542-6895 • All Fees for service will be paid in full before or at the beginning of each session (Cash, credit card, or check.) NO EXCEPTIONS. • If you have insurance you can choose to apply to your insurer for reimbursement. Please ask me for a Statement of your account. <div style="text-align: center; border: 1px solid gray; padding: 5px; margin-top: 10px;"> <p>Go to the FORMS button and choose: DISCOUNT ENROLLMENT PACKET</p> </div>		<p>Fees for service including insurance billing:</p> <ul style="list-style-type: none"> • INTAKE: \$140.00 • REGULAR SESSIONS: \$100.00. • I am willing to bill some insurance companies, however once I bill your insurance you are responsible to pay in full for all services at the above rates. (Based upon my agreement with your insurer's "contract allowables" policy.) • I will bill PRIMARY INSURANCE ONLY. If you intend to submit reimbursement forms to your SECONDARY insurer, please ask me for a Statement of your account. • When I get your insurance company's statement (EOB) which will include their payment to me, I will charge your credit card for any remaining unpaid balance which might include Co-pay and Deductibles. • If I do not get a prompt response from your insurance company, I will charge your credit card for any remaining unpaid balance. You can then seek insurance reimbursement yourself. Please ask me for a Statement of your account. <div style="text-align: center; border: 1px solid gray; padding: 5px; margin-top: 10px;"> <p>Go to the FORMS button and choose: INSURANCE BILLING ENROLLMENT PACKET</p> </div>

4. NO SHOW AND LATE CANCELLATION POLICY

- When you and I schedule a therapy session we are both making a commitment of our time.
- No-shows and Late Cancellations (24 hours) for first or subsequent sessions will be charged **\$60.00** against your credit card.

5. FILLING OUT AND SUBMITTING YOUR ENROLLMENT PACKET

If you need an Enrollment Packet have questions call Connie at: 360-542-6895

1. Choose and print out the Enrollment Packet your prefer. (Or call us and we will send you the packet.)
2. Fill in the blanks on Page 1.
3. Provide your signature in the "CREDIT CARD INFORMATION" section.
4. If you are using your insurance make clear copies of both sides of your insurance card and include them in your packet.
5. Fill in the "CLIENT INFORMATION" section. Fill in the "PARENT or GUARDIAN" if needed.
6. Provide "Client or Guardian" signatures and dates.
7. Read the "DISCLOSURE STATEMENT" . Provide signatures and dates.
8. Mail, Email or Fax the packet following the instructions provided.
9. Chuck will call you to set up your first session as soon as he gets the completed packet.
10. **Please be sure to bring your Original Signed Packet to the first session so Connie can co-sign and we can make copies.**



Connie Bonner-Britt, MA LMHC
360-542-6895
connie@selftimeout.org



FAX 866-492-5137
924 South 11th Street, Mount Vernon, WA 98274

INSURANCE BILLING ENROLLMENT PACKET

WELCOME TO OUR SERVICES

YOU HAVE CHOSEN TO ASK CONNIE BONNER-BRITT TO BILL YOUR INSURANCE COMPANY FOR HER SERVICES.
Your credit card information and your authorizing signature must be on file prior to scheduling the first session. See below.
INSURANCE BILLING POLICY
FEEES FOR SERVICE INCLUDING INSURANCE BILLING AND PAYMENT RULES:
<ul style="list-style-type: none"> • INTAKE: \$140.00 • REGULAR SESSIONS: \$100.00. • Connie is willing to bill some insurance companies, however once she bills your insurance you are responsible to pay in full for all services at the above rates. (Based upon my agreement with your insurer's "contract allowables" policy.) • Connie will bill PRIMARY INSURANCE ONLY. If you intend to submit reimbursement forms to your SECONDARY insurer, please ask her for a Statement of your account. • When Connie gets your insurance company's statement (EOB) which will include their payment to her, she will charge your credit card for any remaining unpaid balance which might include Co-pay and Deductibles. • If Connie does not get a prompt response from your insurance company, she will charge your credit card for any remaining unpaid balance. You can then seek insurance reimbursement yourself. Please ask Connie for a Statement of your account.
NO SHOW AND LATE CANCELLATION POLICY
<ul style="list-style-type: none"> • No-shows and Late Cancellations (24 hours) for first or subsequent sessions will be charged \$60.00 against your credit card. • Coming to the session without payment or cancelling at the time of the session, will be charged against your credit card as a no show. (Including the first session.)

ALL PERSONAL AND CREDIT CARD INFORMATION IS CONFIDENTIAL.

MY INSURANCE WILL BE BILLED \$140.00 after the first (Intake) session and **\$100.00** after each subsequent session.

Insurance Company: _____,

Connie Bonner-Britt agrees to accept your insurance company's "Contract Allowable" limitations.

SEVEN STEPS TO ENROLL FOR SERVICES:

1. PROVIDE YOUR CREDIT CARD INFORMATION

We need your credit card information and your authorizing signature **on file prior to scheduling the first session.**

CHECK YOUR CARD TYPE:		CARD HOLDER NAME AS IT IS ON THE CARD:									
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; border-bottom: 1px solid black;">CARD NUMBER:</td> <td style="width: 20%; border-bottom: 1px solid black;">EXPIRATION:</td> <td style="width: 10%; border-bottom: 1px solid black;">MONTH:</td> <td style="width: 10%; border-bottom: 1px solid black;">YEAR:</td> <td style="width: 30%; border-bottom: 1px solid black;">CVC CODE:</td> </tr> </table>	CARD NUMBER:	EXPIRATION:	MONTH:	YEAR:	CVC CODE:	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border-bottom: 1px solid black;">CITY:</td> <td style="width: 50%; border-bottom: 1px solid black;">STATE:</td> </tr> <tr> <td style="width: 50%; border-bottom: 1px solid black;">SIGNATURE:</td> <td style="width: 50%; border-bottom: 1px solid black;">ZIP:</td> </tr> </table>	CITY:	STATE:	SIGNATURE:	ZIP:
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ACCOUNT BILLING ADDRESS:	STREET:										
No charge will be made to your credit card unless there is an actual session, no-show or late cancellation and an actual balance.											

2. FEES, COPAY, DEDUCTIBLE, NO-SHOW AND LATE CANCELLATION NOTIFICATION: YOU are responsible to pay for all session fees, copay, deductible, no-show and late cancellation charges at the full INSURANCE BILLING RATES: (\$140.00 for the first session, \$100.00 for subsequent sessions or the contract insurance company's "allowed amount". Co-pay and late cancellation fee is \$60.00)

WHATEVER YOU OWE THAT YOU OR YOUR INSURANCE DOES NOT PAY WILL BE CHARGED AGAINST YOUR CREDIT CARD.

3. PROVIDE A LEGIBLE COPY OF BOTH SIDES OF YOUR INSURANCE CARD ALONG WITH THESE FORMS.

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4. PROVIDE THE FOLLOWING INFORMATION TO MEET STATE INFORMATION AND INSURANCE REQUIREMENTS:

CLIENT INFORMATION

Name _____ Date Of Birth _____ - _____ - _____ Age _____ Gender M or F
 Address _____ City _____ State _____ Zip _____
 Home _____ - _____ - _____ Work _____ - _____ - _____ Mobile _____ - _____ - _____
 SSN _____ - _____ - _____ EMAIL ADDRESS: _____

PARENT or GUARDIAN

Name _____ Date Of Birth _____ - _____ - _____ Age _____ Gender M or F
 Address _____ City _____ State _____ Zip _____
 Home _____ - _____ - _____ Work _____ - _____ - _____ Mobile _____ - _____ - _____
 SSN _____ - _____ - _____ EMAIL ADDRESS: _____

5. PROVIDE SIGNATURES COMMITTING TO PAY FEES FOR SCHEDULING AND RECEIVING SERVICES.

I understand that by scheduling any session with Connie Bonner-Britt, MA, LMHC and signing below that I am committed to promptly pay the fees detailed above.

Client or Guardian: _____ Date _____ - _____ - _____

Client or Guardian: _____ Date _____ - _____ - _____

Connie Bonner-Britt, MA, LMHC _____ Date _____ - _____ - _____

6: MAIL / FAX / OR EMAIL THIS 2 PAGE FORM ALONG WITH AN IMAGE OF BOTH SIDES OF YOUR INSURANCE CARD

TO: Connie Bonner-Britt, MA, LMHC
 924 South 11th Street
 Mount Vernon, WA 98274
 or
 FAX a .pdf file to: 866-492-5137
 or
 EMAIL a .pdf file to: connie@selftimeout.org

7. CONNIE WILL CALL YOU TO SET UP YOUR INTAKE SESSION.

PLEASE BRING THE ORIGINAL, SIGNED, TWO PAGE FORM TO YOUR FIRST SESSION SO THAT CONNIE CAN CO-SIGN IT AND MAKE COPIES FOR YOU TO TAKE HOME.



Connie Bonner-Britt, MA LMHC

360-542-6895

connie@selftimeout.org

FAX 866-492-5137

924 South 11th Street, Mount Vernon, WA 98274



DISCLOSURE STATEMENT

We have agreed to do important work together. I have designed this agreement to establish a safe structure for us and also to conform to Washington State Regulations. This structure, along with established professional ethics, protects our work and helps to make our relationship a safe place for growth and change. Please read the following carefully. If, for any reason, you have difficulty understanding any part of it please ask for assistance.

CLIENT RIGHTS:

- You have the right and the responsibility to control your own therapy.
- You have the right to choose a counselor that best suits your needs.
- You have the right to privacy, and information shared during the therapy process will remain confidential unless a signed release is obtained. (See exceptions below.)
- You have the right to ask questions at any time. I will do my best to be responsive.

Therapists practicing counseling for a fee must be registered or certified in accordance with the Counselor Credentialing Act with the Department of Health for the protection of the public health and safety. This empowers you with a complaint process against counselors who would commit acts of unprofessional conduct. Licensing of an individual with the department does not include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment. If you believe I have violated my responsibilities as your therapist, you can contact your local law enforcement agency or the State of Washington Department of Health at (360) 664-9098.

CONFIDENTIALITY:

Under the law, I will disclose confidential information in the following situations:

- When there is reason to suspect the occurrence of child abuse or neglect.
- When there is a clear threat to do serious bodily harm to self or others.
- To a court under court order.
- In the event that you bring charges against me.
- To my office manager, Skagit Medical Billing, for the purpose of record keeping and billing. Skagit Medical Billing has signed a confidentiality statement, which is on file in my office.
- When necessary to insure best practice I will seek consultation from other qualified professionals who are also bound by and respect your right to confidentiality.

COUNSELING GOALS:

The goal is **Voluntary** change. You can choose to change the way you think, and/or behave. It is possible that you may "get worse before you get better." Some experience this as they work at improving. For support with Women's issues you may choose to attend my Women's Circle.

TREATMENT PROVIDED:

I am trained and licensed to provide individual, group and family therapy. I have a Masters Degree in Human Development, and over 20 years experience in the field. I do not discriminate on the basis of race, sex, age, religion, sexual orientation or physical challenges. I am a Child Development Specialist and Children's Mental Health Specialist. I teach Therapeutic Parenting Skills. I operate from a philosophical belief that the therapy process is most effective when the whole family participates. Duration of treatment will be negotiated as the therapy progresses. Good therapy is non-judgmental. I can invite you to look at the consequences of your choices. I have no right to judge anyone.

URGENT OR EMERGENCY SITUATIONS:

EMERGENCY..... 911
 CARE CRISIS RESPONSE SERVICES (24 HOUR)..... 1-800-584-3578
 CHILD PROTECTIVE SERVICES..... M-F 8:00AM TO 5:00PM 1-360-416-720 After hours 1-800-794-9402
 FOR HELP WITH A SELF TIME OUT CALL CONNIE AT... 360-542-6895 She will pick up if she can or return urgent calls as soon as she gets the message.

CLIENT SIGNATURE AND AGREEMENT:

I have received and read this sheet and understand it's content and intent. I understand the limits of confidentiality. I have received my copy of **Counseling or Hypnotherapy Clients, We Want You to Know** provided by the State of Washington for Counseling Clients. I understand that I am responsible to pay for each session in a timely manner. I understand that I may not get the results I want and that I can stop treatment at any time.

Connie Bonner-Britt, MA, LMHC: _____ Date: ____-____-____

Client: _____ Date: ____-____-____

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