CONSENT TO USE ANTHEM HEALTH INSURANCE

Your Name as it Appears on Your Anthem Insurance Card: _____

Your Date of Birth: _____ Relationship to Insured: _____

Insured's Name: _____ Date of Birth: _____

Address: _____ City: _____ St: _____Zip: _____

ANTHEM ID#: _____

Please call Anthem and obtain the following information before your first appointment:

TOTAL DEDUCTIBLE AMOUNT: _____ DEDUCTIBLE MET THIS YEAR: _____ Copay Amount:_____

I, _____ (Client) authorize Louisville Mindfulness Center to release any medical information necessary to my insurance company for me to access my benefits. I understand for me to use my insurance benefits; a diagnosis will need to be assigned to me.

I understand **I am responsible to pay a co-payment of $ _____ per session at the time of service**.

I understand **services provided may not be covered through Health Insurance**. This may be due to diagnosis or service provided. It is my responsibility to determine if health insurance covers the services provided and will provide reimbursement. **If a deductible is due before insurance will pay benefits, I understand I am responsible to pay each session's contracted insurance rate in full** to Louisville Mindfulness Center until that deductible is met. I am also responsible for alerting provider when deductible has been met and co-payment changes.

In addition, I am responsible for all fees NOT paid by insurance, for any reason. If a balance occurs on my account, I agree to a late fee of $25.00 per week, from the last service rendered without payment, until my balance is paid in full.

By signing below, I agree to the above stated terms.

Signature: _____ Date: _____

Client wanted a copy _____

Client did not want a copy _____