ELLIS PSYCHOLOGICAL SERVICES, LLC
1487 CHAIN BRIDGE ROAD, SUITE 303
MCLEAN VA. 22101
P: 703-790-0088
F: 703-940-0684

INSURANCE FORM

Please complete this form if you want Ellis Psychological Services, LLC to submit insurance claims.

Client Name:_____
First Middle initial Last

Client Phone Number:_____

Client Address:_____

City:_____State:_____Zip:_____

Gender: ___F ___M Date of Birth: _____/_____/_____

Name Policy Holder:_____

Policy Holder Date of Birth: _____/_____/_____

Relationship of Policy Holder to Client:_____/ ___Self ___Spouse ___Child

Primary Insurance Company:_____

Primary Insurance Company Address:_____

City:_____State:_____Zip:_____

Primary Insurance company phone number:_____

Insured's ID # (Primary)_____

Insured Group # (Primary)_____

Secondary Insurance Company:_____

Name Policy Holder:_____

Policy Holder Date of Birth: _____/_____/_____

Relationship of Policy Holder to Client:_____/ ___Self ___Spouse ___Child

Secondary Insurance Company Address:_____

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City:_____State:_____Zip:_____

Secondary insurance company phone number:_____

Insured's ID # (secondary)_____

Insured's Group # (secondary)_____

Policy: Your insurance plan is a contract between you and your insurance carrier for specific medically necessary services. You are responsible for understanding your insurance policy (deductibles, copayment, coinsurance, and covered services). You will be financially responsible for services deemed as not medically necessary by your insurance carrier. In order for your services to be covered Dr. Ellis will need to provide the insurance carrier with a mental health diagnosis.

In-Network Plans. If Dr. Ellis is participating in your insurance carrier's network, Ellis Psychological Services, LLC will file the insurance claim and receive payment from the carrier. You must pay the expected copayment, coinsurance, and/or deductible at the time of service. Because insurance carriers do not guarantee benefits until a claim is processed, your expected portion may differ from the initial information provided to you. If your account develops a balance owed, you will be mailed a statement, and payment will be expected within 30 days of the statement. If your account develops a credit, you may have the credit applied to future sessions or receive a refund. Some charges may not be covered by your insurance company and will be your financial responsibility.

Out-of-Network Plans. If Dr. Ellis does not participate in your insurance carrier's network, you are expected to pay the full amount at the time of service. You will be provided receipt for professional services to submit to your insurance carrier to appropriate reimbursement.

I have read and understand the insurance information as stated above. I hereby authorize Ellis Psychological Services, LLC to submit insurance claims to the insurance carrier(s) indicated above. I further hereby authorize Ellis Psychological Services, LLC to release any information necessary to process insurance claim(s). I permit a copy of this authorization to be used in place of the original.

Please provide a copy of both sides of your insurance card.

Patient's/parent/guardian signature:_____

Date :_____