BONNIE L. ATKINSON, Ph.D., L.L.C.
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(256) 767-6139
Mental Health/Behavioral Health
Insurance Benefits Verification Form

Client's Name: _____

Client's Date of Birth: _____

Policy Holder's Name: (If different from client) _____

Policy Holder's Date of Birth: _____Policy Holder's Soc. Sec.# _____

Primary Insurance / Behavioral Health Insurance Plan:

_____
Note: This may be different form your medical health insurance plan.

Member ID# _____ Group# _____

Questions for Your Insurance Provider:

1.) Do I have mental/behavioral health coverage? ☐ Yes ☐ No
(If **YES** continue. If **NO**, there is no need to proceed: other payment arrangements must be made.)

2.) I s my preferred therapist Bonnie L. Atkinson, Ph.D. in network? ☐ Yes ☐ No
(If **Yes**, go to **In-Network Coverage**. (If **No**, go to the next question)

3.) Do I have **Out-of-Network** benefits? ☐ Yes ☐ No
(If **Yes** go to **Out-of-Network benefits**. If **No**, there is no need to proceed: other payment arrangements must be made.)

In-Network Coverage:

4.) What is my co-pay amount? $_____
5.) Do I have a deductible? ☐ Yes ☐ No
6.) If Yes, What is my deductible? $_____
7.) Do I have Co-Insurance? ☐ Yes ☐ No
8.) What is my Co-Insurance amount? $_____
(Now proceed to **Services Covered**.)

Out-of-Network Benefits:

9.) Do I have an Out-of-Network deductible? ☐ Yes ☐ No
10.) If **Yes**, what is my out-of-network deductible? $_____

Services Covered:

11.) Please verify that the following services are covered under my policy.
Individual Therapy ☐ Yes ☐ No
Family Therapy ☐ Yes ☐ No
Group Therapy ☐ Yes ☐ No
Psychological Testing ☐ Yes ☐ No

Services Authorized

Do I need an authorization to receive any of these services? ☐ Yes ☐ No

If **Yes**, what is my authorization number? _____
How many sessions are authorized? _____