RIVER VALLEY
BEHAVIORAL HEALTH
& WELLNESS CENTER

Supplemental Billing Agreement Regarding Insurance Reimbursement

There are instances where insurance companies will not fully reimburse psychological testing services. In some cases, insurance companies will assess the psychological testing as not medically necessary. This varies by insurance carriers on how they view psychological testing. Also, insurance companies may only reimburse for part of the testing that had been provided. Example, your psychologist recommends 4 hours of testing be required for a specific diagnosis, but the insurance company will only reimburse for 2 hours.

Prior to consenting to testing services, it is your responsibility to verify coverage with your insurance company.

At the beginning of your services at River Valley, we can do a verification of benefits and coverage as a courtesy, this is not a guarantee of coverage. You are ultimately responsible for knowing your health coverage and charges. If you ever have any questions, our staff can assist you.

If your insurance company denies coverage of testing or deems it not medical necessary, there are several reasons why this may happen.

1. Testing is considered "experimental"
2. Testing is for Education or Academic purposes
3. Testing requires pre-authorization or a referral
4. Only a certain number of hours are covered.

By signing this form, you understand and agree to pay for all psychological testing and evaluation services. This includes all services not covered by your insurance carrier. The psychological testing and evaluation services not reimbursed by your insurance will be billed to you. These fees range between $225 - $275.

By signing below, I am indication that I understand and agree to the above information. I am agreeing to be "balanced billed" for any hours not approved or reimbursed by my insurance company. I am also indicating that I have called my insurance company to verify coverage for testing and if I have not called, I am agreeing to the possibility of coverage denial and the fees billed for these services.

_____ _____

Client or Parent Signature Date

_____ _____

Client or Parent Printed Name Date

_____ _____

Client name if a Minor DOB of minor