Shibley Psychology

411 Camino del Rio S. Suite 205 619.307.9346
San Diego, CA 92108 admin@shibleypsychology.com

## Insurance Reimbursement

Client name: _____ DOB: _____ SSN: _____

Mailing Address: _____ _____
Number, Street City, Zip Code

Insurance: _____ Policy #: _____

Plan: _____ Group #: _____ Group Name: _____

Insurance Mailing Address: _____ _____
Number, Street City, Zip Code

Insurance Phone: _____

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If the insurance plan is under someone else's name:

Primary Subscriber: _____ Phone: _____

Subscriber mailing address: _____ _____
Number, Street City, Zip Code

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My insurance company has told me that the following apply to outpatient mental health services, but they do not automatically guarantee payment for any service that Dr. Shibley may provide to me.

Deductible: $_____ Co-pay: $ _____ % Coverage: _____
# of visits _____ Authorization required: YES/NO

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I hereby give Shibley Psychology permission to bill my insurance company for services she has provided me or to _____. I also authorize Shibley Psychology to release all necessary information that the insurance company may require to enable her to obtain full payment for her services. I also authorize the use of my signature on all health claim forms for myself or my dependent who has received services from Dr. Shibley.

I also agree to pay Shibley Psychology all amounts owed for service provided by her should my insurance company not fully reimburse her for her services. Such amounts include but are not limited to: co-pays, deductibles, coinsurance (the percentage not covered as shown above), or services not covered for any reason, including fees associated with "no shows" or late cancellations. If such payment is more than 30 days late, I authorize Shibley Psychology to charge the remaining balance to my credit card on file.

In the event that Dr. Shibley is not a contracted provider with my insurance company, I understand that I will be responsible for attaining reimbursement for the costs of therapy, unless other arrangements have been made in advance. I also understand that I am responsible for paying the full fee at the time of service and that, if requested, I will be provided with a monthly "superbill" to submit to my insurance provider for reimbursement.

_____ _____
Signature (Parent or guardian for a minor) Date