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CHECK YOUR INSURANCE PRIOR TO INITIAL VISIT

BEFORE CALLING INSURANCE: INFO TO GET (SOME IS ON YOUR INSURANCE CARD)

1. **Insurance I.D. #:**_____ **Group #:** _____
2. **Primary Subscriber on the Insurance:** _____
3. **Your Relationship to Primary Subscriber:** _____
4. **Primary Subscriber's Birthdate:**_____/_____/_____ **Your Birthdate:** _____/_____/____
5. **Subscriber's Employer**_____
6. **Insurance Plan Phone Number** (*The card may say "Member Services," "MH/SA Benefits," "Behavioral Health", "Mental Health Coverage," "Eligibility and Benefits," or simply "Customer Service"):* _____

THE CALL: WHAT TO ASK THE INSURANCE COMPANY

NOTE YOUR CALL DATE: _____/_____/_____ **REPRESENTATIVE'S NAME**_____

1. I am seeking outpatient mental health benefits in a professional office setting (or via telehealth). Is my provider in network? If not, does my plan also cover out of network providers for this service? If so, what is the coverage? What is my coinsurance or the percentage of the fee I will have to pay for the services?	
2. For Telehealth: Is the coverage temporary? If so, until when? **Is a modifier needed?**	
3. What is my deductible? (The deductible is the amount you must pay out of pocket before the plan begins paying at all. You may have a separate deductible for in-network providers and one for out-of-network providers.) **Check to see.**	
4. How much of my deductible has been met so far this year?	
5. My therapist charges $150/hr. Is this within the Allowed Amount or UCR (Usual, Customary, and Reasonable Fee) for an Out-of-Network Provider? If not, what is the Allowed Amount?	
6. Is a Licenced Clinical Professional Counselor covered by my plan?	
7. Are there any limits to the number of sessions per year?	
8. When do benefits start and renew (you want to know when your deductible renews)? **Is my coverage currently active?**	**Effective:**____/____/____ **Renew:** ____/____/____
9. How do I submit out-of-network invoices to the plan for reimbursement? Do I need to attach another form to my superbill? What is the address for MENTAL HEALTH claims?	
10. What is the Out-of-Pocket Maximum? (The amount you must pay each year before the plan starts paying 100% for health expenses)	
11. Is CPT code 90847 (couples / family therapy) **covered in case I might need this? Is 90791 covered?**	**Yes** _____ **No** _____
12. Can you give me a Call Reference Number for this call?	

Adverse Childhood Experience (ACE) Questionnaire

Name: _____ Date: _____

This Questionnaire will be asking you some questions about events that happened during your childhood; specifically the first 18 years of your life. The information you provide by answering these questions will allow us to better understand problems that may have occurred early in your life and allow us to explore how those problems may be impacting the challenges you are experiencing today. This can be very helpful in the success of your treatment.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often:

   Swear at you, insult you, put you down, or humiliate you?

   Or

   Act in a way that made you afraid that you might be physically hurt?

   ☐ Yes ☐ No If Yes, enter 1 _____

2. Did a parent or other adult in the household often:

   Push, grab, slap, or throw something at you?

   Or

   Ever hit you so hard that you had marks or were injured?

   ☐ Yes ☐ No If Yes, enter 1 _____

3. Did an adult or person at least 5 years older than you ever:

   Touch or fondle you or have you touch their body in a sexual way?

   Or

   Attempt or actually have oral, anal, or vaginal intercourse with you?

   ☐ Yes ☐ No If Yes, enter 1 _____

4. Did you often feel that:

   No one in your family loved you or thought you were important or special?

   Or

Adverse Childhood Experience (ACE) Questionnaire

Your family didn't look out for each other, feel close to each other, or support each other?

☐ Yes ☐ No If Yes, enter 1 _____

5. Did you <u>often</u> feel that:

   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

   Or

   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

   ☐ Yes ☐ No If Yes, enter 1 _____

6. Were your parents <u>ever</u> separated or divorced?

   ☐ Yes ☐ No If Yes, enter 1 _____

7. Were any of your parents or other adult caregivers:

   <u>Often</u> pushed, grabbed, slapped, or had something thrown at them?

   Or

   <u>Sometimes or often</u> kicked, bitten, hit with a fist, or hit with something hard?

   Or

   <u>Ever</u> repeatedly hit over at least a few minutes or threatened with a gun or knife?

   ☐ Yes ☐ No If Yes, enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

   ☐ Yes ☐ No If Yes, enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

   ☐ Yes ☐ No If Yes, enter 1 _____

10. Did a household member go to prison?

    ☐ Yes ☐ No If Yes, enter 1 _____

ACE SCORE (Total "Yes" Answers): _____