Katherine Bruss, Psy.D.
1244 Clairmont Road, Suite 101
Decatur, GA 30030
678-459-5447

INSURANCE PAYMENT POLICY

Dr. Bruss is contracted with Blue Cross/Blue Shield of GA and Aetna. For other insurance companies, she will provide a receipt for services so that clients may file for out-of-network benefits. Services may be covered in full or in part by your health insurance plan depending upon your individual insurance policy. It is your responsibility to read and understand your own insurance policy. Call the number on the back of your insurance card to find out more information about your individual plan. Check with the insurance company to see what your co-pay amount is and whether you have a deductible that you are responsible for until they will begin paying for their amount for your sessions. The copay you pay at the time of your appointment is due at the end of each session and may not contribute to the total out-of-pocket cost that is required by your insurance company. It is not possible to waive the copay amount or hold it in balance. You are responsible for any amount not reimbursed by your insurance company.

If an insurance company indicates that a Provider's fees are above the "usual and customary," please understand that most Provider's fees are above the rate which insurance companies choose to pay for psychological services. The allowable reimbursement rate is most often much lower than the fees normally charged by any psychologist. My fees are comparable with those of other Psychologists in the Atlanta area.

Additionally, you should also be aware of the limits of confidentiality when using your insurance benefits. All companies require a diagnosis from a mental health professional for reimbursing psychotherapy services. Additionally, some companies require a treatment plan with detailed personal information that outlines the nature of the psychological issues.

Be aware that insurance benefits typically change every year. You are responsible for providing a copy of your updated insurance card any time there is a change.

Authorization to pay benefits to Provider and statement of responsibility:

I have fully read and understand this document and agree to meet my financial responsibility and to comply with the terms set forth in this document.

_____ _____

Client Name (Please Print) **Date**

_____

Client Signature

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

_____ _____

Therapist's Signature **Date**