

**Health Insurance Waiver
for BCBS & Other Health Insurance Companies with Out-of-
Network Benefits**

Date _____

By signing below, I agree to waive the separate fee structure set out by my individual BCBS policy for mental health services offered by Caroline R. Baltzer, Ph.D. (Massachusetts license # 7404), and agree to pay Dr. Baltzer directly. I understand that her fee structure is based on the charge for a 50 minute psychotherapy session of \$200, or for a 75 minute session of \$300. I understand that it is Dr. Baltzer's policy that I submit my own claims to BCBS using the insurance-ready bill I receive from her and that I will request on my claim form that the reimbursement checks be made out to me, and sent to me at my address.

I also agree to pay Dr. Baltzer for treatment that is deemed "Non-Covered Service" by BCBS such as phone appointments when necessary, late cancellations (48 hours), and treatment team consultations, as well as other types of clinical administration pertaining to the treatment that my insurance policy doesn't cover.

This waiver and agreement will continue in effect until I have completed my psychological assessment / treatment / consultation with Dr. Baltzer.

Signed,

Member / Patient

Address

Patient/Member copy
 Clinician/Provider copy