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### About Managed Care Insurance

You have chosen to obtain mental health or chemical dependency treatment for which benefits may be available through your health insurance program.

A case reviewer must receive and review information about you and your problems before authorization for treatment will be given. If authorization is not given, benefits may be substantially reduced or be unavailable altogether.

It is your responsibility to contact the managed care company and ask what procedure you must follow to obtain maximum benefits.

**You are not required to contact your insurance company to obtain treatment.** If you prefer that information about you remain completely confidential, you may request that I not contact your insurance company. However, since this will in most cases result in denial of insurance benefits, you must agree to be personally financially responsible for all fees incurred. If you elect to do this, you may file your own insurance claim to see if you can collect any reimbursement.

If you decide to utilize your managed care insurance I will contact the review company and give them enough information so that they can decide whether or not to authorize your treatment. There is a possibility that disagreements may arise between Dr. Grugle and your managed care company over the frequency or duration of your sessions. This is because managed care companies seek to reduce costs to the employer who is providing the insurance. **In most cases, you have a right to reimbursement for medically necessary treatment.** If the managed care company does not approve the treatment that we have agreed upon, you may request an appeal of their decision. If you elect to continue your treatment during the appeal, you must agree to pay all fees incurred that are not reimbursed by your insurance company within sixty days.

The decision to pursue psychiatric treatment should be well informed and considerate of all factors, including finances. To maximize your potential benefits from treatment, it is important that you understand and agree to these conditions. If you have any questions about your insurance coverage or the benefits that are available to you, please ask me or your insurance representative.

Please indicate on the next page your wishes regarding your insurance coverage.

Please read and sign **one** of the statements below

I have read and understand the provisions above. I accept them as applying to the management of my case under my insurance plan and to applications for coverage approval, medical necessity certifications or benefits under my insurance plan with respect to my mental health/chemical dependency care. I authorize Dr. Grugle and my managed care review agency to exchange with each other information relevant to my mental health/chemical dependency condition and treatment for the purposes of case management, claims administration, transition of care, quality assurance, and disability benefit administration (as applicable). I understand that I may at any time revoke my authorization for the exchange of information, except to the extent that action has already been taken in reliance on it. I understand that any revocation must be in writing to Dr. Grugle at his business address and shall not become effective until received by him. If I do not revoke it, this authorization will automatically expire one year after all claims for mental health/chemical dependency treatment have been paid. I also understand that my medical records may be protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse records, 42 CFR, Part 2.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
I have read and understand the provisions above. I do **not** wish to utilize my insurance benefits for treatment rendered by Dr. Grugle and specifically request that Dr. Grugle not communicate with my managed care company regarding my treatment or condition. I understand that I alone will be responsible for payment of all fees incurred. I understand that by executing this part of the agreement I am forfeiting any insurance benefits I may otherwise have been entitled to for this treatment.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness