PART III: Why I Do Not Accept Insurance / Third-Party Payment for Service

I do not take insurance, and I would like to explain why. Under most health care plans today (insurance, PPO, HMO, etc.), these companies offer little coverage and/or reimbursement for mental health services. Most HMOs and PPOs require "preauthorization" before you can receive services. Essentially, this means you or I must call the company and justify your need for services in order for you to receive reimbursement. The insurance representative, who may or may not be a mental health professional, will decide whether services will be allowed. If authorization is given, you are often restricted to seeing the providers on the insurance company's list (who offer truncated and reduced-fee services in order to be placed on this list). Reimbursement is sharply reduced if you choose someone who is not on the contracted list; consequently, your choice of providers is often significantly restricted.

When visits are authorized, usually only a few sessions are granted at a time. When these sessions are finished, there is often a delay in treatment in order to go through the administrative process of requesting more visits. Sometimes additional sessions are not authorized, leading to an end of the therapeutic relationship even if you do not feel you have achieved your therapeutic goals.

Most insurance agreements make it necessary to assign you with a psychiatric diagnosis (i.e., "major depression" or "obsessive-compulsive disorder") in order to get reimbursed. Psychiatric diagnoses may come back to negatively impact you in the following ways:

- increased health insurance premiums;
- denial of insurance when applying for medical and disability insurance;
- company (mis)control of information when claims are processed;
- loss of confidentiality due to the increased number of persons handling claims;
- loss of employment; and repercussions of diagnosis in situations which require truthfulness about "mental illness," including driver's licenses applications, concealed weapon permits, and job applications.

It is also important to note that some psychiatric diagnoses are not even eligible for reimbursement. This is often true for marital and family therapy as well.

Most insurance companies require therapists to submit clinical information about you, such as a treatment plan or summary of the issues discussed in therapy. At times, a copy of your entire record may be requested for review. The individual(s) reviewing your case may or may not have as much training as your therapist. Although insurance companies claim to keep your clinical information confidential, I have no way of guaranteeing that – I obviously have no control over what happens when this information leaves my office. You should be aware that some of your personal information might be added to national medical information data banks. For these and other reasons, many therapists openly talk about "the myth of confidentiality" whenever insurance companies become part of the therapeutic process.