INSURANCE INFORMATION AND RELEASE TO BILL INSURANCE

CLIENT'S NAME_____ D.O.B_____

INSURANCE COMPANY_____

Primary Insured _____ D.O.B._____

Employer_____ I.D. or S.S. _____

Policy#_____ Group# _____

FINANCIAL AND INSURANCE ISSUES: As a courtesy, we will bill your insurance company, HMO, responsible party or third party payer if you wish. We ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, you will be responsible for the full fee for each session until the deductible is satisfied. If your insurance company denies payment or does not cover mental health counseling, we request that you pay the balance at that time. If your balance exceeds $300.00 we will need to ask that you pay for services when rendered. Interest of 1.5% (18 APR) will be charged for any balance greater that 60 days past due. In the event, that an account is overdue and turned over to collection, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed the hourly rate. We will give you a copy of our fee schedule upon request. We sincerely appreciate your cooperation and if, at any time, you have questions regarding insurance, fees, balances or payments please feel free to ask.

Please note: Any patient requested travel, court preparations including letters, documents, e-mail correspondence, and/or court appearances will be billed according to our fee schedule.

The undersigned hereby authorizes the release of information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document will authorize my physician/therapist to submit claims for benefits for services rendered, and for services rendered without my signature on each and every claim to be submitted for myself and/or my dependent. This signature will also bind me as though the undersigned had personally signed the particular claim.

I, _____, hereby authorize _____ (insurance company)

to pay and hereby assign directly to _____(provider of services) all benefits, if any, otherwise payable to me for services as described on all attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to _____, will be credited to my account in accordance with the above said amount. In the event, that the claims are denied, I understand that it is my responsibility to pay the balance due.

Client Signature_____ Date_____

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