Release of Information for Billing Purposes

If you request that I complete insurance forms, you authorize me to make disclosure of your diagnostic information and dates of therapy sessions. Upon revocation of this authorization, further release of information shall cease immediately. This release of information for the purposes of a claim for benefit payment(s) expires upon termination of coverage under the insurance policy or benefit plan or the final determination of the claim, if later.

Insurance (The following questions are about the policy holder)

Policyholder's name: _____ SSN: _____ DOB: _____

Address: _____ City: _____ State: _____

Zip code: _____

Phone: Mobile: _____Work: _____ Home: _____

Insurance company: 1. *(Medical)* _____

2. *(Mental health)* _____

Authorization #: _____ Number of sessions authorized: _____ Co-pay: _____

Employer: _____

Job title: _____

If you are a dependent, what is your relationship to the policyholder: _____

By completing this form, my signature indicates that the information provided is truthful and accurate:

Form completed by: _____ Date: _____

Signature: _____

For Office Use Only

Authorization #: _____ No.Visits Authorized: _____ Copay: _____

Dates of Service: _____ to _____ .

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