INSURANCE AUTHORIZAITON AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers, billing agents and or other practitioners as is required for authorization or billing purposes.

I authorize and request my insurance company to pay directly to the therapist insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____
Signature of client or parent if client is minor Date

_____ _____
Signature of spouse/partner if applicable Date

INSURANCE INFORMATION

Primary Insurance

Client's Name:_____

Client's Date of Birth:_____

Client's Soc. Sec. No: _____

Name of Insured:_____

Insured's Date of Birth:_____

Insured's Soc. Sec. No:_____

Insured's Address:_____

City/State/Zip:_____

Insured's Ph:_____

Relationship to Client:_____

Employer:_____

Insurance Co:_____

Member ID #:_____

Policy Group #:_____

Ins Phone # :_____

Copay _____ # of visits allowed_____ Auth # _____

Secondary Insurance (or spouse's insurance if applicable)

Client's Name:_____

Client's Date of Birth:_____

Client's Soc. Sec. No:_____

Name of Insured:_____

Insured's Date of Birth:_____

Insured's Soc. Sec. No:_____

Insured's Address:_____

City/State/Zip:_____

Insured's Ph:_____

Relationship to Client:_____

Employer:_____

Insurance Co:_____

Member ID #:_____

Policy Group #:_____

Ins Phone #:_____

Copay _____ # of visits allowed_____ Auth # _____

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FOR OFFICE USE ONLY: Effective Date:_____PE?_____

INDV Ded:_____Amt Met:_____

FAM Ded:_____Amt Met:_____

Plan Pays:_____

Max Visits:_____Max Dolloars:_____

PRE AUTH:_____#Visits_____

CoPay_____CoIns:_____

CPT'S: 90791 90834 90837 90846 90847 All EPI#:_____

FOR OFFICE USE ONLY: Effective Date:_____PE?_____

INDV Ded:_____Amt Met:_____

FAM Ded:_____Amt Met:_____

Plan Pays:_____

Max Visits:_____Max Dolloars:_____

PRE AUTH:_____#Visits_____

CoPay_____CoIns:_____

CPT'S: 90791 90834 90837 90846 90847 All EPI#:_____