Client Insurance Information and Release

I authorize the release of medical information necessary to process any of my insurance claims, and I authorize payment of medical benefits directly to **Creative Collaborations Psychotherapy** for services rendered. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. I am aware that I will be charged the insurance allowable rate, or standard fee if private pay for any missed appointments that are not rescheduled or cancelled within 24 hours of the scheduled appointment time.

The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or client that in consideration of the services to be rendered to the client he/she hereby individual obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

Name _____ Signature_____

Date _____

Insurance Information

Company Name: _____ Telephone #_____

Policy Holder's Name _____

Policy #_____ Group # _____

Policy Holder's Social Security Number _____-_____-____ Subscriber's DOB: _____

Relationship to client: _____

Client's Name: _____ Client DOB:_____

To be completed by Billing Office

Date: _____ Spoke with: _____ In Network or Out of Network

Policy effective:_____ Copay per visit: $_____ Coinsurance per visit: $_____

Deductible amount: $_____ Deductible met: $_____

Max Visits/Max Payable per Year _____ Out of Pocket per Year_____

Exclusions to Policy: _____

Claims Address: _____

Authorization #_____Sessions Approved_____ Auth. Dates: _____ thru _____

Notes: