INSURANCE AUTHORIZATION FORM

Patient Full Name _____ Date of Birth _____

Home Address _____ Phone _____

Policy Holder's Name _____ Relationship to Patient _____

Policy Holder's Employer _____

Insurance Company Name _____ Phone _____

Policy # _____ Group # and/or Plan Name _____

Benefit Information *(to be completed by clinician):*

❑ Your insurance company requires prior authorization for all services to be rendered. Initially, _____ sessions have been approved, effective _____ (*authorization #* _____). Additional services cannot be provided without authorization from your insurance company.

❑ Your Employee Assistance Program (EAP) requires prior authorization for all services to be rendered. Initially, _____ sessions have been approved, effective _____ (*authorization #* _____). Additional services cannot be provided without authorization from your EAP.

❑ Your plan coverage is _____% and your co-pay is $_____ per session.

❑ Your plan has a deductible of $_____ and requires an out-of-pocket expenses of $_____.

❑ You have exceeded your benefit maximums for the current year and are, therefore, responsible for all charges until your insurance benefits renew on _____.

Confidentiality Statement: I understand that all information contained in my clinical record is confidential. Those who can access my record are _____. and her administrative staff, as well as myself. All others will require written permission from me to access my clinical record.

Patient Balance Agreement: I understand that if _____ sends invoices to my private insurance company, I am responsible for any portion of the charges not paid by my insurance. I understand that the payment terms of any such balance are due upon receipt of statement.

Authorization to Release Information: I authorize _____ to release and obtain all information necessary to secure payment of any insurance benefits and for the purposes of processing my insurance claims.

Authorization of Benefits: I authorize and request my insurance company to pay directly to _____ all benefits, including the right to payment for services rendered to me.

_____ _____ _____

Signature of Patient Printed Name Date