Insurance Authorization 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 and/or other health practitioners. I authorize and request my insurance company to pay directly to the therapist insurance benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

SIGN HERE

____ _____________________

Signature of Client or Guardian **Date**

Primary Insurance:

Name of Insured: ___________________________________Insured's Birthday: _____________________

Insured's Address: ____

City, State, Zip ____

Phone: ___________________________Relationship to client: ____________________________

Employer: ___________________________Insured SS #: ___________________________________

Insurance Company ___________________________ID & Group#:___________________________________

Insurance Phone #: ____

Client Name: ____

Client's Birthday: _________________________Cient SS #:____

Financial Policy and Agreement

Cancellation

If cancellation is less than 24 hours in advance of your appointment, you agree to pay the cancellation fee of $110.00 for an Initial Appointment and $90.00 for follow up appointments. The same fees apply if you do not show up for your scheduled appointment.

I authorize Kimberly Boyd Counseling Center to charge my credit card listed below, which will be kept on file, the cancellation fee. ________ **Initial Here**

INITIAL HERE

Insurance

Any fees not covered by your insurance company will be charged to your credit card on file. Fees include but are not limited to copayments, coinsurance, and insurance deductibles.

I authorize Kimberly Boyd Counseling Center to charge my credit card listed below, which will be kept on file, any amounts not covered by my insurance company including but not limited to copayments and insurance deductibles. _________**Initial Here**

INITIAL HERE

By signing below, I acknowledge and agree to the Financial Policy and Agreement. I further instruct my credit card issuer to honor any charges subject to the Financial Policy and Agreement.

SIGN HERE

____ _____________________

Signature of Client or Guardian **Date**

Please provide the following information:

Name on Card ____ Visa ___ MasterCard ___ Discover___ Amex___

Credit Card Number ____ Exp Date __________ Sec Code _________

Billing Address ____City _____________State _____Zip _________