Doric George M.A.
Licensed Professional Clinical Counselor #LPC208
Licensed Marriage & Family Therapist #MFC38343

Insurance Information & Consent to Bill

Client Name: _____

Address: _____

_____

Date of Birth: _____

Insured Name (If different):_____

Address: _____

_____

Date of Birth: _____Relationship to insured: _____

Insurance Company: _____ State: _____

ID Number:_____ Group Number: _____

Provider Relations Phone Number:_____

Type of Plan/Name (e.g., PPO, POS, EPO, HMO, Open Access Plus, etc): _____

If any, please list other third party payers such as Health Savings Accounts, other health insurance policies, family member's plans, medical credit cards, reimbursement plans, supplemental plans or any other source of funds used for medical bills: _____

_____

_____

The above information I have provided here is true and complete to the best of my knowledge. If my coverage changes, or if I, the client, would like to seek additional coverage or reimbursement from an additional or different third party payer, I promise to notify this therapist immediately and all current fees and billing procedures may need to be re evaluated, perhaps retroactively, in light of new financial resources and third party requirements.

I also understand that arranged co insurance rates are based on attending weekly appointments and are subject to periodic review.

Rate adjustments maybe made with written and verbal notification at least 2 weeks prior to going into effect.

If 2 consecutive weekly sessions are missed, fees are subject to re evaluation and may be reset to a higher rate.

There is no guarantee as to what amount your insurance company will pay. Insurance companies have their own criteria for fee determination based on usual and customary fees within certain organizations and is subject to change without notice. This determination may vary between carriers and plans. Payments or payment amounts made by the carrier are not guaranteed and are determined at the time of submission by the insurance company. Therefore co insurance fees may need to be adjusted in the event of changes in insurance coverage.

I authorize the release of any medical or other information necessary to process insurance claims. I also authorize payment of medical benefits directly to the provider of services, Doric George MA.

Name Printed: _____ Signature: _____ Date: _____