Client Insurance Information and Release

I, _____, authorize the release of medical information necessary to process any of my insurance claims. I authorize payment of medical benefits directly to Healing Relationships, LLC for services rendered. I understand and agree that regardless of my insurance status, I am responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should that 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 with 24 hours' notice. I understand that fees related to cancellations or no-shows are not covered by insurance and will be my sole responsibility. Healing Relationships, LLC encourages the signor to update the provider of any changes to insurance in advance so that financial considerations can be discussed.

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 individually 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.

Printed name: _____

Signature: _____ Date: _____

Insurance Information

Company Name: _____

Telephone #_____

Policyholder: _____

Policy #_____ Group #_____

Policyholder Social Security Number _____-_____-_____

Policyholder DOB: _____

Relationship to client: _____

Client 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: