Insurance and Billing Information

Insurance Information (Please attach a copy of your Insurance Card):_____

Have YOU notified your insurance company about these visits? Y/N

Insurance Company:_____ Phone:_____

PPO Network:_____ CoPay:_____

Group Policy No:_____ Deductable:_____

Subscriber Name:_____ DOB:_____

Claims Address:_____

Employer Name:_____

Benefit Information:_____

Authorization Number(if required):_____

Insurance Assignment/Release and Agreement

I, _____, hereby authorize my insurance benefits to be paid directly to the Therapist and I understand that I am financially responsible for non-covered services. I also authorize the therapist to release any information required to process the insurance claims. Ian an appointment is cancelled and missed without **24** hours notice, I understand that I will be billed for the session.

_____ _____

Client Signature Date

I authorize Cornerstones Counseling Center to process payments from my credit card(information provided here) for services rendered and/or and other fees associated with my personal balance due, this includes, copays, co-insurances, deductibles, denied claims, claims unpaid by insurance for more than 120 days.

Credit Card Information

Name on Card:_____

Billing Zip Code:_____

VISA/MasterCard(circle one)

Card Number:_____

Exp Date:_____ CVV:_____

Cardholder's Signature:_____