synchrOnicity COUNSELING

Marci Danielson, M.S., LMFT

Insurance Billing Agreement

Name_____

Date of birth_____ SSN _____

Insurance Company_____

Policy Holder's Name _____ID number_____

Policy Holder's date of birth_____SSN _____

Policy Holder's employer_____

Primary Care Physician's Name_____

Phone Number _____

May this Physician be contacted for continuity of care? _____Yes _____No

Be advised that by signing for me to bill your insurance company you understand that auditors from that company have the right to come in and inspect and read your file. All of your diagnostic information is submitted to them after each session. Confidentiality is not preserved when insurance companies are billed. If you do not wish for me to bill your insurance company you will be responsible for the full cost of services at each session. In addition, by signing this document your agree to take full financial responsibility for any session fees where coverage was declined by your insurance company.

_____ Client accepts the above statement and wishes to bill insurance

_____ Client declines to have insurance billed and agrees to pay the full amount for each session.

_____ _____

Client/Parent or Guardian Signature Date