synchrOnicity COUNSELING Nichole Jordan, M. Coun., LCPC, NCC

Insurance Billing Agreement

Your name_____

Date of birth_____ SSN_____

Insurance Company _____ Policy number_____

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 doctor be consulted for continuity of care? Yes____ No____

BE ADVISED THAT BY SIGNING FOR US TO BILL YOUR INSURANCE COMPANY YOU UNDERSTAND THAT AUDITORS FROM THAT COMPANY HAVE THE RIGHT TO COME IN AND INSPECT AND READYOUR FILE. ALL YOUR DIAGNOSTIC INFORMATION IS SUBMITTED TO THEM AFTER EACH SESSION. CONFIDENTIALITY IS NOT PRESERVED WHEN INSURANCE COMPANIES ARE BILLED. IF YOU DO NOT WANT US TO BILL YOUR INSURANCE COMPANY YOU WILL BE RESPONSIBLE FOR THE FULL COST OF SERVICES AT EACH SESSION. IN ADDITION, BY SIGNING THIS DOCUMENT YOU AGREE TO TAKE FULL FINANCIAL RESPONSIBILITY FOR ANY SESSION FEES DECLINED COVERAGE BY YOUR INSURANCE COMPANY.

☐ CLIENT ACCEPTS THE ABOVE STATEMENT AND WISHES TO BILL INSURANCE

☐ CLIENT DECLINES TO HAVE INSURANCE BILLED FOR SERVICES AND WILL PAY THE FULL COST OF SERVICES AT THE TIME OF EACH SESSION

_____ _____

Client / Parent or Guardian Signature Date