



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 READ YOUR 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