CECILIA CARTER Counseling

_____ _____

Client Name Date of Birth

Authorization for Release of Information to Insurance Company

I authorize Cecilia Carter Counseling, LLC to release billing information which may include client name, date and type of services, diagnoses codes, substance abuse information and/or treatment plans to my insurance company/ies for the purpose of: collecting insurance benefits or for authorization of additional sessions for:

- I understand that I have the right to inspect the information released through this authorization and such an inspection will occur in a meeting with Cecilia Carter.
- I understand that I may revoke this authorization by providing a written revocation.
- I also understand any information released prior to the revocation may be used for the purpose(s) listed above.
- A photocopy of this authorization shall have the same force as the original.
- This release shall be valid for one year following our last appointment, unless otherwise restricted.

Name of Insured:	
Insurance Company-	
Insurance Company Phone Number:	
Policy Number:	
Group Number if applicable	
Date coverage started if listed on card	
Co pay listed on card	

_____(Initial) Your Insurance Provider MAY cover all your fees, ultimately it is your responsibility to cover all your costs.

_____ (Initial) Some plans require preauthorization before your first visit. It is YOUR responsibility to obtain this authorization.
_____ (Initial) Mental Health benefits may differ from your medical benefits so it is essential that you have researched your mental health benefits prior to your visit. If you have not done this prior to your visit, and/or your treatment is not a payable benefit, you will be responsible for the full cash payment at the time of service. Further, if your insurance carrier determines that the services received are not medically necessary, you will be responsible for full payment of your accrued fees.

My signature below indicates I authorize Cecilia Carter, MA, QMHP, LPC, to provide services to me and acknowledges my role as the guarantor for services rendered.

_____ _____

Client/Parent Guardian Signature Date

_____ _____

Witness Signature Date