

INSURANCE INFORMATION

Please call your insurance company for your copay amount and pre-authorization. Not all insurance policies require pre-authorization. Please provide me with the information below.

Name of Insurance Company_____

Copay amount per your insurance company_____

Authorization # given by insurance company_____

Number of sessions authorized_____

Effective dates of authorization_____

What date did you call the insurance company_____

Other relevant information_____

ASSIGNMENT OF BENEFITS: I hereby authorize direct payments of mental health benefits to Carol Graybeal, MSW, LCSW, BCD for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION RELEASE INFORMATION: I hereby authorize Carol Graybeal, MSW, LCSW, BCD to release any medical/mental health information that may be necessary for either medical care or in processing applications for financial benefit. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be considered as valid as the original.

Client Signature (and Parent/Guardian signature when appropriate)

Date