INSURANCE INFORMATION

Please call your insurance company for co pay amount and pre-authorization. Not all insurance policies require pre-authorization. If your policy does not require pre-authorization, please note below.

Name of Insurance Company_____

Co pay amount per your insurance company_____

Authorization # given by insurance company_____

Number of sessions authorized_____

Date insurance company was called by you_____

Other relevant information_____

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

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Joy Shivas 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 valid as the original.

_____ _____

Client Signature (and Parent/Guardian signature when appropriate) Date