Release of Information for Insurance Billing

Michaele (Shelly) Knous, MS, LCPC
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Name of Client: _____

Client Date of Birth: ___/___/_____ **Client SS#:** _____

Name on Policy: _____

Relationship to Client: _____

Policy Holder Date of Birth: ___/___/_____ **Policy Holder SS#:** _____

Policy Holder Address: _____

Policy Holder Phone Number: _____

Name of Insurance Company: _____

ID Number: _____

Group Number: _____

Number for Pre-Authorizations and/or: _____

Number Listed on Back of Insurance Card: _____

I request that payment of authorized insurance benefits be made on behalf of Michaele Knous, MS, LCPC for any services furnished. I authorize Michaele Knous, MS, LCPC to release any information pertinent to processing a claim to the insurance provider.

_____

Signature **Date**

_____

Signature **Date**

I will attempt to contact your insurance company in an attempt to verify benefits for the counseling sessions. While I make this effort, I cannot guarantee that the information I get from your insurance company is consistent with what they actually will cover. I recommend that all clients refer to their insurance policies to verify their own benefits. Please know that I will contact your insurance company in an attempt to resolve any unpaid claims.

Clients are responsible for paying any amounts that their insurance company does not pay. Any bills unpaid for 90 days will be sent to a collection agency and any service fee charged by the collection agency (approximately 33% of the final bill) will be charged to the client(s).