Jennifer Danhauser, LPC
Counseling and Therapy Services

Billing Agreement

I understand and agree that it is my responsibility to check with my insurance carrier regarding coverage of counseling and what types of providers are covered under my plan.

Client Information

FIRST NAME: _____ M.I. _____

LAST NAME: _____

ADDRESS: _____

_____

HOME PHONE: _____ BUSINESS PHONE: _____

CELL PHONE: _____ EMAIL: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

Other Responsible Party

If someone other than the client is responsible for payments, please fill in the information below:

FIRST NAME: _____ M.I. _____

LAST NAME: _____

ADDRESS: _____

_____

HOME PHONE: _____ BUSINESS PHONE: _____

CELL PHONE: _____ EMAIL: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

Billing Agreement

Primary Insurance

INSURED'S ID#: _____ INSURED POLICY, GROUP OR FECA#: _____

INSURANCE COMPANY: _____

Primary Insured

If someone other than the client is the primary insured for this policy, please fill in the information below:

FIRST NAME: _____ M.I. _____

LAST NAME: _____

ADDRESS: _____

_____

HOME PHONE: _____ BUSINESS PHONE: _____

CELL PHONE: _____ EMAIL: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

RELATIONSHIP TO CLIENT: _____

ASSIGNMENT OF BENEFITS

I authorize payment by my insurance company to be paid directly to these independent practitioners: Jennifer Danhauser, LPC, Cathy Weeg, LPC or Mike Worrall, PhD. for services rendered. Please note, these practitioners may differ regarding their preferred/non-preferred status with your insurance company. I understand that I am financially responsible for charges applied to the insurance deductible and for all charges limited by the insurance carrier. I authorize Jennifer Danhauser, LPC, Cathy Weeg, LPC or Mike Worrall, PhD. to give copies of any records when needed for payment by my insurance carrier and/or its affiliates.

_____ _____

Client or Legally Responsible Person **Date**

_____ _____

Jennifer Danhauser, LPC **Date**