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**