INSURANCE FEE AGREEMENT
AND
AUTHORIZATION FOR THIRD PARTY BILLING

Clients
***Name**_____

INFORMATION REGARDING GUARANTOR OR PERSON PROVIDING INSURANCE PLAN:

***Insureds Name:**_____ **Relationship:**_____

***Address:**_____

***City:**_____ **State:**_____ **Zip:**_____ **Phone:**_____

***S.S.#:**_____ **D.O.B.**_____/_____/_____

***Employer:**_____ **I.D.#:**_____

***Insurance Name**_____ **Group#:**_____

I understand that Christian Counseling Center (CCC) will assess a fee of $120.00 for my first session and $100.00 per session thereafter and I authorize CCC to bill my insurance company for this fee. I further understand that I will be responsible for any portion of my fee, not covered by my insurance. Payment is expected from me at the time of service unless prior arrangements have been made by contracted agreement with my insurance company. Any payment that is made by me and later reimbursed by my insurance company will be refunded to me or applied to future visits at my request.** ***I understand that unless I provide a 24 hour notice of cancellation that a $50.00 fee will be my responsibility.

***I authorize CCC to release Protected Health Information as required by my insurance company in order to obtain authorization or payment for services rendered. I understand that this information may be shared by written, faxed, or electronic means.**

_____ *****_____
Witness **Client**

_____
Date

AASSIGNMENT OF BENEFITS

I hereby authorize payment to be made directly to Christian Counseling Center.

_____ *****_____
Witness **Client**

_____
Date

TURN OVER FOR SELF-PAY

Office use only: **INSURANCE VERIFICATION**

Date: _____ Deductible_____ Co-Pay_____ or Co-insurance _____

Authorization: Required Y or N Authorization #: _____