



Consent for Third Party Billing

If you choose to pay for therapy using a third party payer such as a community agency or insurance company, I will typically submit authorization and claims forms directly to them. Third party payers typically do not cover fees for missed appointments, telephone consultations and certain other kinds of services.

Please carefully review with your payer all information about amount and type of services they cover. If you have questions, please contact your payer. If you remain unclear about what is being provided, I will be glad to contact the payer and attempt to clarify the situation. It is particularly important to understand that third party payers may authorize payment for a specific number of sessions only or may require that I request their approval of additional sessions after an initial allocation. Third party payers may make their own decisions, independent of my recommendation, about how much or what kinds of treatment they will pay for or believe is necessary.

Third party payers frequently require some information about your case when they agree to pay for treatment. Information required depends on the payer. Some examples of required information may include treatment attendance, or treatment information such as description of presenting problems, diagnosis (when applicable), treatment type or plan, progress or treatment summary. You are welcome to discuss what is disclosed to payers with Bill McClain, LCSW at any time. Although community agencies or insurance companies are typically required to keep such information confidential, I have no control over what they do with this information once it is in their files.

By signing below, you agree to release all information necessary to the payer in order for me to obtain reimbursement for services, and you authorize direct payment to me by the payer. It is the client's responsibility to obtain authorization from any third party payer, prior to the first appointment. Furthermore, the client is responsible for payment for all services rendered and charges incurred that are not covered by a third party payer.

IF YOU WISH TO HAVE A THIRD PARTY BILLED PLEASE COMPLETE AND SIGN THE FOLLOWING

Client Name and Date of Birth: _____

Parent/Guardian Name: _____

Signature: _____ **Date:** _____

Insurance Company or other 3rd Party Payer: _____

Insurance Group & ID# _____

Primary Insured Person: _____ **Date of Birth** _____

Address of Insured Person: _____

Employer of Insured Person: _____

Secondary Insurance Information (if any): _____