Kelland Psychological Services, LLC

Authorization to Collect Treatment Costs from a Medical Insurance Provider

Authorization:

This document serves as your written authorization to allow Kelland Psychological Services to collect costs of your psychological treatment from a medical insurance provider. Your signature and date at the center of this form acknowledges that you have reviewed this form, provided Kelland Psychological Services with your insurance information, and have given express permission to attempt to collect costs from identified insurer.

Deductible:

In some instances, there may be a deductible value that must be met before the insurance provider will cover the costs of your treatment. In such instances, you may be required to provide the full cost of session via cash, credit/debit card, flexible spending/health care account card, or check.

Copayment:

In most instances, there will be a required copay for your treatment session. This amount is set by your insurance provider and must be paid at the time of treatment.

Insurer Nonpayment:

In the event your insurance provider does not cover the cost of your treatment, you or a responsible party will be required to meet the costs of any outstanding balance on your account.

_____ _____ _____

Patient/Guardian Printed Name **Patient/Guardian Signature** **Date**

Patient Birthdate: _____ Patient Social Security #:_____

Insurance Provider: _____

Insurance Member Id: _____

Insurance Group/Policy Id: _____

Responsible Party: _____

Responsible Party Address: _____

Responsible Party Telephone: _____

Responsible Party Employer: _____

Deductible: _____ Copay: _____

Note: A copy of your driver's license/state id/passport and a copy of your insurance card are required to bill insurance for coverage of your treatment.

Patient Name: _____