

Insurance Authorization Form

I authorize Cypress Family Guidance Counseling to keep my signature on file and to charge my Credit Card listed below for:

- Balance of charges not paid by insurance or patient within 90 days.
1. I the undersigned accept financial responsibility for payment of all fees at the time of the visit, unless other arrangements have been made with your therapist.
 2. Authorization for release of information: I hereby authorize the release of information regarding me/my child's condition or treatment to insurance company.
 3. Authorization to pay insurance benefits to the provider: I hereby authorize the payment of increased benefits from my insurance company to my provider.

- Full session fee of \$ _____ (Initial _____) for missed appointments and late cancellations.

Please be advised 3rd party payers (i.e., insurance companies) will not reimburse your therapist for your missed appointment. Consequently you will be responsible for the full amount when appointments are missed or not cancelled within 24 hours. Medicaid members will not be charged per state law; however your therapeutic relationship can and may be terminated following 3 missed appointments.

I understand that this form is valid for one year unless I cancel authorization through written notice to the service provider. I understand that the card given to this provider for charges in office will be kept on file.

Customer's Name: _____

Cardholder's Name: _____

Patient (or responsible party) Signature: _____

Date of Signature: _____ / _____ / _____