4705 Lacey Boulevard, Ste. D
Lacey, WA 98503

ANN R. HOWIE, LICSW, ACSW

Voice: 360-493-2586
FAX: 360-455-1318

Authorization for Insurance Payment

Client	Insured	
Client's Name:	Insured's Name:	
Client's Street Address:	Insured's Street Address:	
Client's City, State, Zip:	Insured's City, State, Zip:	
Client's Phone Number:	Insured's Phone Number:	
Client's Social Security or Medicare Number:	Insured's Social Security Number:	
Client's Date of Birth:	Insured's Date of Birth:	
Client's Employer:	Insured's Employer:	
Insurance Plan/Program Name:	Insured's ID Number:	Insured's Group Number:

I understand that I am responsible to understand the type of insurance coverage I have. In addition, I know how many visits are covered annually, my co-payment amount, and my annual deductible. Should I elect to use my health insurance benefits to pay for psychotherapy, I understand that my diagnosis, symptoms, history, and substance abuse (if any) will become part of my permanent records. I understand that my insurance company has the right to access and copy any and all of this information, as well as all clinical documentation of my treatment. I am aware that in some cases this information may be submitted to insurance databases and/or to employers when they are the purchaser of my medical/mental health benefits.

Depending upon the plan, the therapist may submit bills directly to my insurer, or we may agree that I am responsible for this. In all situations, I understand that my co-payment is due at the beginning of each session. In the event that my insurance denies coverage for services rendered for any reason, I am responsible for paying the outstanding balance.

I request that payment of authorized insurance benefits be made on my behalf to Ann R. Howie for all services furnished by her. I authorize any holder of mental health information and/or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I further authorize Ann Howie to communicate with my health insurance company and its agents to obtain information needed to determine my benefits or to obtain the benefits payable for her services.

Signature: _____ Date: _____
Client/Parent/Guardian

NOTE: This form is used in lieu of the patient's signature on the "Request for Payment" form HCFA-1500 and is, therefore, an extension of that form. Anyone who misrepresents or falsifies essential information in making claims may, upon conviction, be subjected to fine and imprisonment under Federal law.