Authorization for Use/Disclosure of Information to Insurance Company

I authorize________________________________ (Clinicians Name) to release billing/medical information which may include client(s) name(s), date and type of services, diagnoses codes, substance abuse information, treatment and/or any other information needed to my insurance company/ies for the purpose of: Collecting insurance benefits, obtaining coverage information or for authorization of additional sessions for:

____ _____________________________

Client Full Name Date of Birth

____ _____________________________

Client Full Name Date of Birth

- I fully understand that I have the right to inspect the information released through this authorization and such an inspection will occur in a meeting with Jaclyn Sullivan.
- I fully understand that I may revoke this authorization only by providing a written revocation to Jaclyn Sullivan.
- I also fully understand any information released prior to the revocation may be used for the purpose(s) listed above.
- I fully understand that it is my responsibility to know what my benefits entail, my eligibility, coverage, co-pay's and any deductibles I may have under my plan not Jaclyn Sullivan or Sullivan Counseling Inc. I release Jaclyn Sullivan of all responsibility and will not hold her or Sullivan Counseling Inc. liable or accountable for any of the specifics of my plan/coverage, any changes, omission, discrepancies or my comprehension of such.
- This release shall be valid from the date it is signed below up until one year following my last appointment with Jaclyn Sullivan, unless otherwise restricted.

Signature of Client or Legal Guardian: ________________________________ Date: ________________________

Witness: ____ Date: ________________________

Primary Insurance Information:

Insurance Company Name:	Client Name:
Insurance Company Address:	Policy Holders Name:
Insurance Company Phone Number:	Policy Holders Address:

Policy Number or Member ID:	Policy Holders Date of Birth:
Group Number (if applicable):	Co-Pay:

Secondary Insurance Information:

Insurance Company Name:	Client Name:
Insurance Company Address:	Policy Holders Name:
Insurance Company Phone Number:	Policy Holders Address:
Policy Number or Member ID:	Policy Holders Date of Birth:
Group Number (if applicable):	Co-Pay:

** Clinicians will need to photocopy of insurance card(s)

<u>NOTE:</u> Although your insurance MAY cover most of your fees, ultimately it is your responsibility to cover all your costs. Some plans require preauthorization before your first visit. It is your responsibility to obtain this authorization. It is also your responsibly to know what your benefits entail, your eligibility, co-pay and any deductibles that you may have. Mental Health benefits may differ from your medical benefits so it is essential that you have researched your mental health benefits prior to your visit. If you have not done this prior to your visit, and/or your treatment is not a payable benefit, you will be responsible for the full cash payment at the time of service. Further, if your insurance carrier determines that the services received are not medically necessary, you will be responsible for full payment of your accrued fees.

<u>Re-Disclosure:</u> I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.