Bloomfield Hills Marriage & Family Therapy, PLLC

Insurance Company Billing Authorization

I, _____, authorize **Bloomfield Hills Marriage & Family Therapy, PLLC** and their billing company associates to release information to my insurance company as required by my insurance company and deemed necessary for the processing of claims related to the specific services rendered by my service provider.

I fully understand that I am responsible for any deductibles, co-pays, and/or co-insurance as required by my insurance plan coverage. I agree to pay my portion of the fees owed at the time of services rendered.

In the event that my insurance company does not pay for the services rendered, I agree to pay for all session at the stated fee for service.

Insurance Company: _____

Contract Number: _____

Cilent DOB: _____

Signature: _____

(Patient) (Parent if under 18) (Date)