Insurance Billing Information

Client's Name: _____ Date of Birth: _____

Address: _____

Name of Person Carrying Insurance: _____
(if not client)

Address (if different): _____

Phone number: _____ Date of Birth: _____

Employer: _____

By signing below, you are agreeing to pay all fees incurred from your treatment, including any fees not covered by your insurance.

_____
Signature

Co-pays are due at time of service

My co-pay is $_____

I will be using an HSA card to pay for my sessions _____