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**Growth Pointe Wellness**

**Dana Graves, MA, LMHC**

# INSURANCE INFORMATION /

**AUTHORIZATION FOR RELEASE**

You are requested to pay for services at the time they are rendered. You may choose to pay the full fee at the beginning of each appointment and then submit your bill to your insurance company for reimbursement. However, upon request and receipt of the necessary information, the therapist will bill your primary insurance for the portion of the cost that your insurance carrier will cover with you paying the balance or co-pay at the beginning of each session. There is no guarantee that your insurance company will pay for your sessions. ***In the event that your insurance company declines to pay, you would be responsible to pay the therapist, Dana Graves, for your entire amount billed.***

Please complete the following insurance information. List only your primary insurance carrier and present your card to your therapist. You are responsible for billing your secondary insurance carrier.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Insurance/Recipient of Protected Health Information Telephone # of Insurance (on back of card)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID No. Group / Plan Name**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group No. Plan/Branch No.**

**Subscriber’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**First Middle Initial Last**

**Subscriber’s**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**No. Street City State Zip**

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**Subscriber’s Birth Date Subscriber’s Employer**

**REVOCATION/REDISCLOSURE**: I understand that this authorization can be revoked in writing at any time, except to the extent that substantial action may have already occurred based on prior authorization to disclose information to effectuate payment. Unauthorized redisclosure is prohibited.

**DURATION:** Length of time needed for completion of payment for services provided to client.

**SIGNATURE**: This authorization covers protected health information pertaining to **Benefit Information/Billing/Payment.**

I authorize Dana Graves, MA, LMHC/Growth Pointe Wellness to release any medical or other information *(commonly called, protected health information)* necessary to process manual or electronic claims for my insurance.

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Signature Date

I hereby assign payment of insurance benefits directly to: **DANA GRAVES, MA, LMHC**

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Signature Date

**Growth Pointe Wellness 600 Main St., Suite D Edmonds, WA 98020 425.359.9801**