HIPAA/INSURANCE RELEASE FORM

CK Counseling will bill your insurance company for reimbursement of services. Please verify with your prover you have behavioral health/mental health coverage. It is your responsibility to pay any co-pay or deductible you may have at the time of service.

Insurance: ___________________________________
Name of Member Holder: __________________________
Date of Birth: __________ (MM/DD/YYYY)
Member ID number: ________________________________
Group Number:____________________________________
Effective Date:___________(MM/DD/YYYY)
Co-pay amount: $ _________

I agree to be responsible for the payment or copayment for services rendered by Christa Kay Clarke, MA, LPC, NCC, RPT. I understand, and agree that regardless of my insurance status, I am ultimately responsible for the balance of this account. I understand that appointments must be cancelled 24 hours in advance or I will be charged for the session. I understand that late cancellations or no-shows will be billed to me and not to my insurance company. I certify that all answers to the foregoing questions are true and correct to the best of my knowledge. I agree to notify you and any changes in my insurance or the information provided above.

Signature: _________________________________ Date:______________

HIPPA Agreement

Your insurance company may require release of information regarding your therapy. This release will be either verbal or written and will contain information including, but not limited to, your diagnosis, progress in therapy, the current problems being addressed, and expected prognosis. It is necessary for your consent in order to release this information . If you choose not to sign this form, therapy may have to terminate if your insurance company is one that requires this information for ongoing treatment.

Signature:___________________________________ Date:_____________