Rowan-Bailey Counseling, LLC
12465 S. Fort Street, #250, Draper, UT 84020

Authorization to Bill Insurance

I _________________________ (print name) do hereby give full permission and authorize Rowan-Bailey Counseling, to bill services rendered by Rowan-Bailey Counseling. I authorize the release of any medical or other information necessary to process my claims.

By signing this document I also agree to the following statements:
I understand that I am responsible for understanding information about my health insurance policy and providing such information to Rowan-Bailey Counseling, for correct billing. I am also responsible to notify Rowan-Bailey Counseling in the case of change of my health insurance status – including benefits and any information I receive relating to care I have or will receive in this office. I understand that Rowan-Bailey Counseling will be providing services and billing my health insurance for those services at various times during the course of my care at this office. I understand that ultimately I am responsible for all payment relating to any and all charges relating to treatment and services that I have received at Rowan-Bailey Counseling. I also understand that my insurance company and related policy plan may offer benefits for services provided at Rowan-Bailey Counseling, but that such benefits do not necessarily guarantee payment for those services.

I understand the above information and agree that my health history and related information was completed correctly to the best of my knowledge and understand that it is my responsibility to alert Rowan-Bailey Counseling of any change in my medical status or insurance coverage.

Client Name ______________________________ Date of Birth: _____/ _____/ _____

Marital Status: Single Married Separated Divorced Widow Partner

Name of Employer/School: ____

Insurance ID Policy #: _________________ Group #:_______________

Policy holder's Name: ____

Date of Birth: _____/_____/_______ Social Security #(Tricare only): ______-______-________

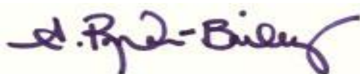
Policy Holder's Employer: _______________________________________

Patient Relationship to Insured: Self Spouse Child Other

The undersigned does agree to observe and abide by all of the statements made above.

____

Client Signature Date



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RBC Representative Signature Date