Authorization to Bill and Payment Policy
Tax ID: 92-0161193

Patient Name: _____ DOB: _____

Primary Insurance Information
Subscribers Name: _____ Subscribers DOB: _____
Relation to Subscriber:_____

Primary Insurance Company: _____
Insurance Address: _____
Insurance Phone Number: _____
ID#_____Group #_____

Secondary Insurance Information
Subscribers Name: _____Subscribers DOB: _____
Relation to Subscriber: _____

Secondary Insurance Company: _____
Insurance Address: _____
Insurance Phone Number: _____
ID#_____ Group #_____

As a courtesy, we will bill your insurance company for the services provided. Per your insurance, this is not a guarantee of payment. All claims are subject to review according to your plan provisions and limitations. Please review your policy for specific details on your plan coverage, co-pays and deductibles. We will not be responsible for monitoring your dollar or visit maximums on your plan, as this is the patient's responsibility. While Psychology Resources will submit claims on your behalf, it is your responsibility to manage and resolve any payment issues with your insurance company. Full payment is expected for any unresolved issues or non-payments with your insurance within 60 days of the date of service. Psychology Resources will not be held responsible for any additional non-covered or over the usual and customary charges that is determined by the insurance company.

Your signature below indicates you read and understand the payment policy and authorize Psychology Resources to submit claims to your insurance company(s).

Signature_____Date_____
_____

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