# Payment Authorization

____ I am uninsured. I agree to pay the amount per session assigned by my counselor. Please sign the bottom section of this form.

____ I am insured but do not wish to have my insurance billed**. I understand this means I am responsible for the full $95 fee and do not qualify for the sliding scale fee.** Please sign the bottom section of this form.

____ I am insured. Please read and complete all of the information below.

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**PLEASE BRING YOUR INSURANCE CARD TO YOUR INITIAL APPOINTMENT.**

Prior to your appointment please call your insurance company to verify the following items:

What is my copay for mental health specialist: $______ Has my deductible been met: Y/N

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Name of insurance company:_________________________________________

Client Name: ______________________________________________________

Birthdate: _____/_____/_______

Address: _________________________________________________________

_________________________________________________________

_________________________________________________________

Phone: (____) ______-_______________

By signing below, I hereby authorize my insurance to make payment directly to Catholic Charities, the designated provider, for any services furnished to me by that provider.

By signing below, I hereby authorize the designated provider, Catholic Charities, to release any information acquired in the course of my treatment to my insurance company, that is necessary for processing my insurance claim.

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Client Signature or signature of client's legal guardian:__________________________________________

Print name if different than client:__________________________________________________________

Date:_______________________

COUNSELOR USE: BE SURE TO GET A CLEAR COPY OF THE FRONT AND BACK OF INSURANCE CARD

Counselor name:

Date of first session: ___/___/________ Diagnosis: