Catholic Charities
of the Diocese of Raleigh

Providing Help–Creating Hope–Serving All

Treatment Authorization

____ I am uninsured. 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 the information below.

PLEASE BRING YOUR INSURANCE CARD TO YOUR INITITAL 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

Client Name: ____

Birthdate: _____/_____/_______

Address: ____

____

____

Phone: (____) ______-________________

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: