TRANSFORMATIONS
THERAPY OF ATLANTA

Insurance Agreement

This form is to notify you of the circumstances surrounding the filing of insurance claims for mental health services.

Many insurance companies will require for mental health professionals to release certain details related to sessions in order to pay for the services rendered. This information can include health information, treatment goals and progress and related information to support the goals and assessment of progress.

It is understood that you agree to allow the therapist to provide related information regarding your treatment to insurance agencies in order to receive reimbursement.

It is also understood that it is your responsibility to verify your benefits, including copayment and deductibles.

If any portion of a claim is returned unpaid by an insurance company, it is understood that the client is responsible for payment of this balance. Therapist will notify client of the unpaid balance and the card on file will be processed for the amount due, unless the client provides therapist with an alternate form of payment.

It is your responsibility to make sure you update your therapist on any changes to your insurance information.

Please provide the following regarding your insurance along with a copy of your insurance card (back and front):

Primary insurance company:_____

Phone number: _____

Address to mail claim: _____

_____

Name of Insured: _____

ID Number:_____

Group Number: _____

Employer Information (For primary insured)

Name: _____

Address:_____

Relationship to insured: ___ self ____parent/guardian

_____

Client printed name and date

_____

Client Signature and date

_____

Parent/Guardian Signature if applicable