

Cathy Weeg, LPC
Counseling and Therapy Services

Billing Agreement

I understand and agree that it is my responsibility to check with my insurance carrier regarding coverage of counseling and what types of providers are covered under my plan.

FIRST NAME: _____ M.I. _____

LAST NAME: _____

ADDRESS: _____

HOME PHONE: _____ BUSINESS PHONE _____

CELL PHONE: _____ EMAIL _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____

Responsible Party #1

If someone other than the client is responsible for payments please fill in the information below:

FIRST NAME: _____ M.I. _____

LAST NAME: _____

ADDRESS: _____

HOME PHONE: _____ BUSINESS PHONE _____

CELL PHONE: _____ EMAIL _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____

Primary Insurance #1

INSURED'S ID# _____

INSURANCE COMPANY: _____

CLIENT RELATIONSHIP TO INSURED: _____

INSURED POLICY, GROUP OR FECA#: _____

Responsible Party #2

If someone other than the client is responsible for payments please fill in the information below:

FIRST NAME: _____ M.I. _____

LAST NAME: _____

ADDRESS: _____

HOME PHONE: _____ BUSINESS PHONE _____

CELL PHONE: _____ EMAIL _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____

Primary Insurance #2

INSURED'S ID# _____

INSURANCE COMPANY: _____

CLIENT RELATIONSHIP TO INSURED: _____

INSURED POLICY, GROUP OR FECA#: _____

ASSIGNMENT OF BENEFITS

I authorize payment by my insurance company to be paid directly to Cathy Weeg, LPC for services rendered. I understand that I am financially responsible to Cathy Weeg, LPC for charges applied to the insurance deductible and for all charges limited by the insurance carrier. I authorize Cathy Weeg, LPC to give copies of any records when needed for payment by my insurance carrier and/or its affiliates.

Client/Legally Responsible Person

Date

Cathy Weeg, LPC

Date