

Jennifer Danhauser, 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.

Client Information:

FIRST NAME: _____ M.I. _____

LAST NAME: _____

ADDRESS: _____

HOME PHONE: _____ BUSINESS PHONE _____

CELL PHONE: _____ EMAIL _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____

Responsible Party

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: _____

CLIENT RELATIONSHIP TO INSURED: _____

Insurance Information:

Primary:

PLEASE CHECK IF THE NAME ON THE INSURANCE CARD IS:

SELF _____ OR RESPONSIBLE PARTY _____

INSURED'S ID # _____

INSURANCE COMPANY: _____

INSURED POLICY, GROUP OR FECA #: _____

Secondary (Complete only if applicable):

PLEASE CHECK IF THE NAME ON THE INSURANCE CARD IS

SELF _____ OR RESPONSIBLE PARTY _____

INSURED'S ID # _____

INSURANCE COMPANY: _____

INSURED POLICY, GROUP OR FECA #: _____

ANY OTHER INSURANCE INFORMATION THAT WOULD BE BENEFICIAL FOR YOUR COUNSELOR TO BE AWARE OF:

ASSIGNMENT OF BENEFITS

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

Client/Legally Responsible Person

Date

Jennifer Danhauser, LPC

Date