AUTHORIZATION TO BILL INSURANCE

I, _____,
client name date of birth

hereby authorize Diane C. Moore, MA, LPC

to bill my insurance company/employee assistance program for my treatment.

My Subscriber/Member ID

_____.

My Group Number (if applicable) is _____.

Insurance phone number to verify mental health benefits

_____.

The primary subscriber (if not myself)

_____, DOB _____,

Primary subscriber's address (if different from mine)

_____
_____

Employer _____

I understand that my diagnosis will be provided to my insurer. I understand that the insurance company may request additional clinical information regarding my treatment progress in order to authorize sessions and/or payment, and I authorize Diane C. Moore, MA, LPC, to provide such information as necessary.

_____ _____
Client or Guardian's Signature Date