

Faith Winters, LLC Insurance Agreement With Client

**COMPLETE THIS PAGE ONLY IF YOU HAVE EAP OR HEALTH INSURANCE COVERAGE
AND YOU WOULD LIKE FAITH WINTERS TO BILL YOUR INSURANCE COMPANY**

Insurance Billing Information

- As a courtesy to you Faith Winters will bill your insurance company with your written authorization.
- Your health insurance benefit is a contract between you and your carrier. Please verify your coverage with your insurance company. They should provide you with: Co-Pay amount, dollar or visit limitation and deductible information if applicable. Please make payment in full for your visits until your insurance benefit has been verified. Co-pays and deductible are to be paid at the time of service. Any portion not covered by insurance is your responsibility.
- Most insurance companies issue a reference wallet card on which this information appears. Otherwise you might need to check with your insurance representative.

Client Name _____ Date of Birth _____
Month - Day - Year

Client's Home address _____

Primary

Health Insurance Plan: _____

ID or Group # information _____

Your Deductible \$ _____ Your Co-Pay per visit \$ _____

Mailing address: _____

City _____ State _____ Zip _____

Insured's name: _____ Date of birth _____
Month - Day - Year

Home address _____

City _____ State _____ Zip _____

Secondary

Health Insurance Plan: _____

ID or Group # information _____

Your Deductible \$ _____ Your Co-Pay per visit \$ _____

Mailing address: _____

City _____ State _____ Zip _____

Insured's name: _____ Date of birth _____
Month - Day - Year

Home address _____

City _____ State _____ Zip _____

Authorization to bill insurance:

I hereby authorize Faith Winters to release any necessary health information needed to bill my insurance carrier. I also authorize payment to be made directly to Faith Winters for services billed.

I reserve the right to limit the information given to my insurance carrier. Limitations I want will be discussed with my treating therapist and given in writing.

Client or authorized person's signature _____ Date _____

FOR OFFICE USE ONLY:

Primary Co-pay _____ Deductible _____ Secondary Co-pay _____ Deductible _____

Benefits _____