APOGEE COUNSELING ASSOCIATES

SIGNATURE ON FILE FORM

Insurance Company: _____

Name of policy holder: _____

Social Security Number of policy holder: _____

Name of client if different from above: _____

1. I authorize use of this form on all my insurance submissions
2. I authorize release of information to all my insurance companies
3. I understand that I am responsible for my bill as stipulated in my insurance policy
4. I authorize Apogee Counseling Associates to act as my agent in helping me obtain payment from my insurance company
5. I agree to verify my coverage with my insurance company and make all co-payments at the time services are rendered
6. I permit a copy of this authorization to be used in place of the original.

I request that payment of authorized behavioral health care benefits be made directly to Apogee Counseling Associates, Darryl K Moore, PhD, or Ryan Berwold, LMFT or my named therapist here: _____

I understand that my signature requests that payment be made and authorizes release of all medical information necessary to pay the claim.

Signature authorized releasing of the information to the insurer or agency shown. In health care benefits assigned cases, the physician or supplier agrees to accept the charge determination of the carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services.

Patient / Parent/ Guardian signature: _____

If not patient, list relationship:_____

Date: __ __/__ __/ __ __ __ __