PHOENIX RISING COUNSELING
28a Mashamoquet Rd, Pomfret Center CT. 06259
PH. 860-792-6396 Fax 860-932-3506

AUTHORIZATION TO BILL INSURANCE

1. I understand that services provided by Phoenix Rising Counseling to me/my child will be billed to my health insurance carrier.

2. I understand that if my health insurance carrier and/or plan changes, it is my responsibility to inform my therapist of the change. I also understand it is my responsibility to provide my new/updated health insurance information and a copy of my new/updated health insurance card(s).

3. I understand that Phoenix Rising Counseling will submit my/my child's health insurance claims to my health insurance carrier first and that I will be responsible for any deductible, co-payments, co-insurance, or client fees at the time services are rendered.

4. I understand that I will receive a monthly statement if my/my child's account has a balance due. I also understand that termination of my/my child's services/treatment may occur if my/my child's account remains unpaid after 30 days. I further understand that a legal claim may be filed against me for non-payment after 90 days.

5. I understand that Phoenix Rising Counseling cannot accept responsibility for collection of my/my child's health insurance claim(s) or for negotiating a settlement on a disputed claim and that I am responsible for payment of my/my child's account.

6. I understand that if my health insurance carrier for which I have provided information is not active or rejects my/my child's health insurance claim(s) for reasons outside of Phoenix Rising's control, I am responsible for paying for the session(s) at a rate of $100.00 per session.

7. If I am using my health insurance, I consent that my health insurance carrier can receive certain information about our work. This information usually includes diagnoses, treatment goals, and a plan for achieving those goals. I understand that my/my child's clinician cannot refuse providing this information to my health insurance carrier. I understand that I may choose to pay privately for treatment in order to avoid any disclosure to my health insurance carrier.

I hereby authorize Phoenix Rising Counseling to bill my health insurance carrier for provided services and to release to my health insurance carrier and/or other third-party payers my/my child's diagnoses, dates of service, and other required information for financial reimbursement purposes.

BY SIGNING BELOW, I AM ACKNOWLEDGING THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE TERMS DETAILED IN THIS DOCUMENT.

Client or Parent/Guardian Signature _____Date_____