CARAMENICO COUNSELING GROUP LLC

800 West State Street – Suite 303 • Doylestown, PA 18901

BILLING AND PAYMENT FOR SERVICES

Client Name:_____ **D.O.B.:** _____

I, _____, _____,
(print full name) (Relationship to the client)

authorize Caramenico Counseling Group LLC to contact my insurance carrier in order to review my available mental health benefits. I further authorize Caramenico Counseling Group LLC to release any medical, diagnostic, clinical, or other information necessary to process claims of payment for services rendered. In addition, I authorize insurance to release payment for services rendered to Caramenico Counseling Group LLC.

I agree to pay any copay, co-insurance, deductible, or other fee for service at the time services are rendered to me by the independent practitioner at Caramenico Counseling Group LLC. I understand that payment is only accepted in the form of cash or check and is to be made payable to Caramenico Counseling Group LLC. If the client is under the age of 18, I affirm that as his/her parent/guardian I accept financial responsibility for payment for services rendered to my child.

My signature also indicates that I understand that it is my responsibility to inform Caramenico Counseling Group LLC of any changes in my insurance coverage. If my insurance coverage is cancelled or I have reached my maximum benefit for mental health service, I understand that Caramenico Counseling Group LLC will bill me directly for services rendered.

Client Name Signature Date
(All clients age 18 and older are required to sign this document)

Parent/Guardian Name Signature Date
(Parent/Guardian must sign if child is under the age of 18)

Independent Practitioner Signature and Credentials Date

☐ Client (or Parent/Guardian) was provided a signed copy of this document.
☐ Client (or Parent/Guardian) declined a signed copy of this document.

Information Updated August 2016