AUTHORIZATION/RESPONSIBILITY AGREEMENT

Shelley Burns, MA, LMHC #LH00005879
P.O. Box 1688; Duvall, WA 98019
425/844-2103
sburns.counseling@gmail.com
BurnsCounseling.com

DATE________________________CONFIDENTIAL EMAIL ADDRESS____________

CLIENT NAME___________________________________BIRTH DATE____________

ADDRESS(mailing & physical)____

HOME PHONE____________________CELL/WORK PHONE #s__________________

SOCIAL SECURITY #_________________EMERGENCY PHONE _______________

PRIMARY CARE PHYSICIAN______________________PHONE__________________

PERSON RESPONSIBLE FOR BILL________________________BIRTHDATE______

ADDRESS____

PHONE NUMBERS____________________SOCIAL SECURITY #_________________

INSURED NAME (if different)_____________________________BIRTHDATE_______

ADDRESS____

PHONE NUMBERS____________________SOCIAL SECURITY #_________________

INSURANCE COMPANY_____________________EMPLOYER___________________

GROUP #_________________________INSURED IDENTIFICATION #_____________

SECONDARY INSURANCE CO.____________INSURED NAME________________

ADDRESS____

PHONE NUMBERS____________________SOCIAL SECURITY #_________________

BIRTHDATE______________________INSURED IDENTIFICATION #____________

EMPLOYER_______________________GROUP NUMBER________________________

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REFERRAL INFORMATION

I am very interested in knowing how you chose to seek counseling services from me. Please check off the source of your referral.

Physician___
Other professional___
Yellow pages___
Printed advertising materials____
Other______________________
Internet_____
Insurance provider list____
Managed care referral____
Friend____

RESPONSIBILITY AGREEMENT

I acknowledge that I am responsible for payment for all services rendered to the above named client. Payment in full is expected at each session unless otherwise arranged prior to the beginning of the session. Once authorization is established for insurance coverage, I understand I will be responsible for the co-pay at the time of service. **I understand that any charges over 90 days old are my responsibility and are subject to collections proceedings.** Whether I bill my insurance company directly or the provider bills the insurance company on my behalf, I hereby authorize any insurance company to pay the proceeds of any benefit due me directly to **Shelley Burns.**

I agree to pay__________________per hour for services.

Signature____Date____________