

**AUTHORIZATION/RESPONSIBILITY AGREEMENT**

**Shelley Burns, MA, LMHC #LH00005879**  
425/844-2103  
[sburns.counseling@gmail.com](mailto:sburns.counseling@gmail.com)  
[BurnsCounseling.com](http://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 _____	Internet _____
Other professional _____	Insurance provider list _____
Yellow pages _____	Managed care referral _____
Printed advertising materials _____	Friend _____
Other _____	

### 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 \_\_\_\_\_