Alyse M. Scura, LMHC

NYS License #6008

AUTHORIZATION TO BILL INSURANCE

Insurance Information

Responsible Party Name: _________________________________ Self ☐ Spouse ☐ Parent ☐ Other ☐

Address: ____ Phone:___________________________

Birthdate: ________________________Employer: ____

Insurance Company/Address: ____

Phone Number (_________) __________________________ Mental Health/Specialist Co-Pay: _________

Policy Number ________________________________ Group # ________________________________

Have you met your annual deductible? Yes ___ No ____

All co-pays or co-insurance payments are due at the time of the service. If the deductible has not been met, you will be responsible for paying the full fee until the deductible has been satisfied. In addition, if your insurance company does not satisfy payment of your service, the below signed client is responsible for the fee as discussed ($60/session).

By signing below, I consent to a diagnostic evaluation, treatment and any other clinical procedures which are advisable during my care with Alyse M. Scura, LMHC. Additionally I also consent to Alyse M. Scura, LMHC, contacting insurance companies on my behalf for billing purposes and utilizing this and/or a signed insurance form when submitting claims.

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Signature of Client or Responsible Party and Date

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Printed name of Client or Responsible Party