Authorization to Bill & Release Information to Insurance Company

Client Name:	Client Date of Birth:

This is to authorize that the information specified below regarding the above person be disclosed between:

Maya Sprague, MA, LMHC 1622 Third Street, Suite 9 Marysville, WA 98270 Phone: (425) 418-2949	**&**	
		Insurance Company
		Street
		City, State, Zip Phone:
		Attention:

I certify that I am eligible for benefits under my prepaid health benefit plan. In the event that I am later found to be ineligible or in consideration of being treated without proof of eligibility, I agree to pay for any and all services provided by my individual practitioner based upon regular fees then in effect. I understand that all co-pays will be due at the time of service and that all non-covered, co-insurance, and deductible amounts must be paid within 30 days of receipt of notice from my insurance or Prestige Medical Billing Company. I grant permission to **Prestige Medical Billing Co., Inc**. to submit claims on my behalf to my insurance carrier for services provided by **Maya Sprague**. I authorize the release of any medical or other information necessary to process my claims. I authorize payment of medical benefits to **Maya Sprague** directly from my insurance carrier.

I understand that my records may contain information relating to mental health issues. I also understand that my written consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), psychiatric disorders/mental health, and/or drug and/or alcohol use. If I have been tested, diagnosed, or treated for any of these things, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment. This authorization prohibits further use of disclosure of the information being released beyond the specific limits of this consent. I understand that I may cancel this authorization at any time, except to the extent that the action has already been taken. Unless canceled earlier by me, this authorization will expire in ninety (90) days from the signature date.

Signature: _____ Date: _____

Client _____ Parent _____ Legal Guardian _____