

Eric Stephen Jannazzo, Ph.D.
Licensed Psychologist
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Benefit Company Authorization Agreement

If you believe your medical insurance may cover the costs of all or part of your services, and you wish to use these benefits, please provide a copy of your insurance card and complete the following information:

Your Name:

Your DOB:

Insurance Company/Plan:

Insurer's Phone Number (likely on back of ID card):

Group Policy Number:

Insurance ID Number:

Your Address:

Your Phone Number Associated with Coverage:

Your counselor will file your insurance claim for you, unless your insurance company requires otherwise. However, **you are strongly encouraged to contact your insurance company** to ask them for information regarding your co-payment and deductible for "outpatient mental health services." It is recommended you contact them before your first or second session. This will help you determine the appropriate payment or co-payment for your counseling sessions. **All self-pay payments and co-payments must be paid at the beginning of each session.** If your insurance plan requires a physician's referral, please contact your doctor before your first session.

AUTHORIZATION FOR DISCLOSURE OF MENTAL HEALTH INFORMATION AND AGREEMENT TO PAY

I, _____, on my own behalf authorize **Eric S. Jannazzo, Ph.D.** to release mental health information to my insurance company to the full extent specified under any or all Federal laws and Washington State statutes, or as subsequently amended, to provide utilization review and quality assurance service for the administration of claims for benefits. I further authorize **Eric S. Jannazzo, Ph.D.** to directly receive all payment of benefits due, unless I am responsible for payment of services rendered.

This authorization allows **Eric S. Jannazzo** to release information to my insurance company, to administer claims submitted, or to be submitted for payment, to conduct a utilization and quality control review of mental health care services provided or proposed to be provided, or to conduct an audit of claims paid.

I acknowledge that I am aware that I may inspect the information disclosed at any time, and may revoke this authorization at any time if I provide written revocation to **Eric S. Jannazzo, Ph.D.** and thus, I agree to accept financial responsibility for mental health care services provided if my insurance should deny claims for benefits because of the inability to examine my mental health records.

I certify that all the information is true, accurate, complete, and I agree to be personally responsible for all reasonable charges not paid by my insurance company.

Client Signature: _____ Date: _____

Parent/Guradian Signature (if applicable): _____ Date: _____

SS Number: _____