Art Therapy Insurance Billing Authorization

Client Information

Client Name:

Date of Birth:

Phone Number:

Email Address:

Insurance Information

Insurance Company:

Policy Number:

Group Number:

Subscriber Name:

Subscriber DOB:

Authorization

☐ I authorize my art therapist to release information necessary to process insurance claims. ☐ I understand I am responsible for any amount not covered by my insurance. ☐ I consent to the release of my health information as required for billing.

Signature

Client/Guardian Signature

Date