Art Therapy Insurance Billing Authorization

Client Information

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 funderstand 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	Client Name:
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	Signature
Date	Client/Guardian Signature
	Date

