
Release of Information to Insurance Company

Policy Holder's Full Name_____

Date of birth _____ Identification # _____

Insurance Company Name and Address_____

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Policy # _____

I understand that I am financially responsible for all charges incurred regardless of whether or not they are covered by my insurance policy.

I authorize Inner Life Psychological Services to release the information required by my insurance company for the purposes of filing claims for reimbursement to me for payment for ser vies.

I understand that information that may be requested by my insurance company is typically considered private and confidential.

I understand that my signature is on file and is valid for the duration of treatment until such time as all balances have been paid in full.

I understand that my insurance provider does not cover the cost of any cancelled sessions.

Signed_____ Date_____

Witness_____Date _____