Consent for Third Party Billing

By Orchard Human Services, Inc.; Kristy Larkin, LCSW; and/or Darleen Claire Wodzenski, LPC

If you choose to pay for therapy using a third party payer such as an insurance company or community agency, we will typically submit authorization and claims forms directly to them. Third party payers typically do not cover fees for missed appointments, telephone consultations and certain other kinds of services. Please carefully review with your payer all information about amount and type of services they cover. If you have questions, please contact your payer.

Please be aware that sometimes third party payers may authorize payment for a specific number of sessions or require that we request their approval of additional sessions after initial authorization. Third party payers may make their own decisions, independent of our recommendation, about how much or what kinds of treatment they will pay for or believe is necessary.

Third party payers frequently require some information about your case when they agree to pay for treatment. Information required depends on the payer. Some examples of required information may include treatment attendance, or treatment information such as description of presenting problems, diagnosis (when applicable), treatment type or plan, progress or treatment summary. You are welcome to discuss what is disclosed to payers with us at any time. Although community agencies or insurance companies are typically required to keep such information confidential, we have no control over what they do with this information once it is in their files.

By signing below, you agree to release all information necessary to the payer in order for Orchard Human Services, Inc. and/or Kristy Larkin, LCSW and/or Darleen Claire Wodzenski, LPC to obtain reimbursement for services, and you authorize direct payment to us by the payer. It is the client's responsibility to obtain authorization from any third party payer, prior to the first appointment. Furthermore, the client is responsible for payment for all services rendered and charges incurred that are not covered by a third party payer.

IF YOU WISH TO HAVE A THIRD PARTY BILLED PLEASE COMPLETE AND SIGN THE FOLLOWING:

Client Name:_____ Date of Birth _____

Parent/Guardian Name: _____

Signature: _____ Date: _____

Insurance Company or other 3rd Party Payer: _____

Insurance Group & ID#_____

Primary Insured Person: _____Date of Birth_____

Address of Insured Person: _____

Employer of Insured Person: _____

Secondary Insurance Information (if any): _____