

Ellen Savage

Amalia PC

Licensed Clinical Professional counselor #27

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_____ I/We authorize use of the form on all my insurance submissions.

_____ I/We authorize release of information regarding billing to all my insurance companies.

_____ **I/We understand that I am responsible for my bill.**

_____ I/We authorize my doctor/provider and billing company (Back Office Solutions, LLC) to act as my agent in helping me obtain payment from my insurance companies.

_____ I/We authorize payment direct to doctor/provider when billing is not sent by yourself.

_____ I/We permit a copy of this authorization to be used in place of the original.

_____ I/We have reviewed a copy of HIPAA standards for this office.

Do we have your permission to call your phone and leave a message?

***Home phone** Yes _____ No _____

Cell phone Yes _____ No _____

Work phone Yes _____ No _____

Regarding appointments? Yes _____ No _____

Regarding account information? Yes _____ No _____

Name(s) _____ / _____

Signature(s) _____ / _____

Date ____/____/20____

PLEASE NOTE! IF YOU ARE BEING SEEN IN THIS OFFICE FOR AN INITIAL VISIT AS A COUPLE, BOTH OF YOU MUST SIGN THESE FORMS. THANK YOU.

