THE CENTER FOR MINDFUL EXPLORATION
1111 Mooty Bridge Road, Ste A / PO BOX 800154
LAGRANGE, GA 30240

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, give full authorization to provide/exchange information regarding my mental health information to/with:

_____
Name of Insurance Provider

_____ _____
Insurance ID # Group #

_____ _____
Name of Insured Insured's Date of Birth

for the purpose(s) of: Billing

I understand that authorization shall remain valid from the date of my signature below and ending one year from the date this authorization is signed. I have been informed that I may revoke this authorization at any time.
I certify that this form has been fully explained to me and that I understand its contents.
INSURANCE POLICIES: Please be aware that some insurance companies require the insured patient to contact them in advance of any scheduled visit to obtain pre-authorization for services. You are solely responsible for meeting this or any other obligation of your contract with your insurance company prior to the time of your visit. Your insurance co-payments and deductible fees are required in full at the time of service,
Your insurance coverage is a contract between you and your insurance company. As a courtesy to you, I will be happy to file a claim for your visit on your behalf**. The ultimate responsibility for payment, however, remains with you.** Accordingly, any account balance over thirty (30) days old will be billed directly to you. Should your account have to be collected through a collection agency or an attorney, you shall also be responsible for all reasonable attorney's fees and all costs of collection. Please be aware that all unpaid balances will be referred to a collection agency if you fail to fulfill your financial obligations

_____ _____
Signature of Client or Legal Guardian Date of Authorization