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PATIENT AUTHORIZATION FORM

PATIENT NAME: ____

HEALTH INSURANCE: ____

MANAGED CARE COMPANY: ____

SUBSCRIBER: ____

CONTRACT ID# ______________________________ GROUP # ____________________

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENTS OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.

MANY POLICIES REQUIRE THAT YOU CALL BEFORE YOUR FIRST APPOINTMENT FOR PREAUTHORIZATION. ALL VIRGINIA STATE EMPLOYEES ARE REQUIRED TO DO SO.

PATIENTS ARE RESPONSIBLE FOR CALLING THEIR INSURANCE COMPANY PRIOR TO THE FIRST VISIT WITH EACH THERAPIST SEEN. DO NOT ENTRUST THIS CALL TO ANYONE ELSE; IT IS TOO IMPORTANT. IF AUTHORIZATION IS NOT OBTAINED, YOU WILL BE RESPONSIBLE FOR THE FULL AMOUNT OF THE CHARGE. HAVE YOU CALLED FOR AUTHORIZATION? ______YES ______ NO

PATIENT'S OR AUTHORIZED
PERSON'S SIGNATURE: ____

DATE: ____

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