Thriving Roots Counseling, LLC

Authorization to Bill Insurance

& to Release Medical Information to Insurance

I, _____, hereby give my consent for Thriving Roots Counseling and Sabrina Sheehy, LCSW to bill my insurance carrier for the services rendered. In addition, I agree to pay Thriving Roots Counseling, LLC /Sabrina Sheehy, LCSW any copay or uncovered charge in accordance with my health care plan and/or the discussed fee agreement.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV, sexually transmitted disease, psychiatric disorders, or drug/alcohol use. I, _____, hereby give my consent for Thriving Roots Counseling, LCC and Sabrina Sheehy, LCSW to release medical and other relevant information to my insurance carrier as required by my insurance carrier to process medical billings/claims.

Client Signature: _____ Date: _____

Insurance Company: _____

Plan Name: _____ Company/Employer Name: _____

ID #: _____ Group #: _____

Are you the primary insured? Yes ☐ No ☐ If no, please list the name and birthdate of the primary insured and how you are related:

Primary Insured: _____ Birthdate: _____ Relationship: _____

Thriving Roots Counseling, LLC
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