Agreement of Payment by Insurance Companies

Client's Name as it appears on your card (including the middle initial):

_____

Name of Insurance Company: _____

Your policy number: _____

Group Number: _____

Date of Birth: _____

By signing this form, you agree to allow Maira Holzmann, LCSW to use your signature for Insurance reimbursement or other insurance entities including Victim of Crime.

Patient is responsible for payment of the agreed upon fee for any missed session(s). Patient is also responsible for payment of the agreed upon fee for any session(s) for which Patient failed to give Therapist at least 24 hours notice of cancellation.
Cancellation notice should be left on Therapist's voice mail at 760-889-9319.

Client Signature: _____

Today's Date:_____