Empowered Hearts Therapy, LLC

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Agreement to Utilize Insurance

Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you so instruct only the minimum necessary information will be communicated to the carrier. All copays, coinsurances, and outstanding balances are expected to be paid at start of session.

Client Name: _____ DOB: _____ Age: _____

Phone: (home) _____ (cell) _____

Address: _____

_____

Insurance Provided by: ☐ Self ☐ Parent ☐ Guardian ☐ Spouse ☐ Other:_____

Name: _____ DOB: _____ Age: _____

Phone: (home) _____ (cell) _____

Address: _____

_____

Use of insurance does not guarantee reimbursement. Client is ultimately responsible for fees for services.

_____ _____

Print Parent/Guardian Name **Relationship to child**

_____ _____

Signature **Date**