Arches Counseling and Trauma Treatment

PRIVACY OF RECORDS AND INFORMATION RELEASE FOR BILLING PURPOSES

I acknowledge the use of a billing service (*Claims Connection, Inc*) located in Plattsburgh, New York to bill for those charges to be issued to my insurance company. When technology permits, these claims may be submitted electronically.

I acknowledge *Claims Connection, Inc* being given a copy of my registration form in order to process these claims and/or maintain a record of my account.

If necessary, I authorize *Claims Connection, Inc* to contact my insurance company to check on the claims submitted for payment of services.

client name: _____

client or guardian signature: _____

date: _____