Better Mental Health Services
1684 E. Gude Dr, Suite 102
Rockville, MD 20850

Release of Information
Insurance Reimbursement

Client name: _____ DOB: _____

Insurance name (BCBS, United, etc):_____

Insurance Member ID number:_____

I agree to allow Better Mental Health Services, LLC to give/gain all necessary information relevant for payment for my treatment with the insurance company listed above. I understand that I have the right to limit any Person Health Information, but that exercising this right may result in non-payment for services and possible termination. I understand that this release is valid for the full extent of my treatment and can be rescinded by written request at any time.

Client Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____