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 (BMHS) 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 I understand that this release is valid for the full extent of my treatment and can be rescinded by written request at any time. By signing below, I am also acknowledging that my insurance plan is being used as a form of payment, and that I will be held personally responsible for all costs related to copays, deductibles, or denied insurance claims for the duration of my treatment, as BMHS is submitting claims for me as a courtesy.

Client Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____