

RICHARD SLADICH, MS, LPCA

BILLING INFORMATION (Attach copy of insurance card if filing insurance)

CLIENT NAME: _____
First Name Last DOB (MM/DD/YYYY)

Address City State Zip Code

Name of Insurance Company Policy Number (Subscriber or Recipient ID #) Group Number

Policy Holder's Name (If different from client) DOB (MM/DD/YYYY) Relationship to Client

Address (If different from client address above) City State Zip Code

Social Security Number (of person responsible for bill) Employer (If employer insurance policy)

Phone Number home mobile work other

SIGNATURES

I have read, understand and agree to Richard Sladich, MS, LPCA's Professional Disclosure Statement. I understand that I am responsible for payment of any and all services rendered by Richard Sladich, MS, LPCA and that such payment is due at the time of the visit, which may include deductible balances, co-insurance and co-payments. My signature below indicates that I fully understand and agree to these terms.

Signature of person responsible for payment Date

I authorize RICHARD SLADICH, MS, LPCA to release any Protected Health Information to my insurance provider that is required by them to process an insurance claim. I authorize my insurance provider to pay benefits to RICHARD SLADICH, MS, LPCA. I understand that I am responsible for payment of services rendered to me by RICHARD SLADICH, MS, LPCA regardless of reimbursement for these services by my insurance provider. I understand that any inaccuracy in information I provide could result in nonpayment by my insurance provider, for which I am personally responsible to pay. I agree to immediately notify RICHARD SLADICH, MS, LPCA whenever there are changes in my/the client's health condition or health plan coverage.

Signature (for insurance billing) Date