**CLIENT BILLING FORM**

Thank you for choosing to receive your or your care from Welsh Therapy and Associates.

We are not in-network for any insurance companies and as such, we require patients and/or identified responsible parties to pay up front for all services. These fees are nonrefundable after the completion of each appointment. Although you may receive reimbursement from your insurance company for some or all of the cost of care, you must identify who will provide payment at the time of service.

We accept cash, check or credit card. Please bring your form of payment to each appointment. Please also complete the credit card authorization form for at least one credit card, which will be kept on file as to ensure payment for services.

Who will be responsible for paying for services provided to you or your child by Welsh Therapy and Associates?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (put “self” if you will be responsible) Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Submission of a reimbursement request form:** You must submit a request to your insurance company asking for reimbursement. Each insurance company’s process for requesting reimbursement is slightly different. If you would like your insurance company to reimburse you, you should visit your insurance company’s website or contact them to learn how to request reimbursement. Most insurance companies have a form you can download from their website, complete, and submit to them to request reimbursement. When you submit your reimbursement request, you must include proof that you received services. I can provide you that proof in the form of a specialized health care services receipt, called a Superbill. If you would like to submit a request for reimbursement to your insurance company for a service provided to you by Welsh Therapy and Associates, please ask me to give you a Superbill for that service.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_