INSURANCE AUTHORIZATION

I hereby authorize Robert Goddard, Ph.D. and Goddard Psychological Services to release any or all information necessary to process my insurance claim. I also authorize that payment of same be made directly to Goddard Psychological Services, Robert Goddard, Ph.D., Licensed Psychologist.

I understand that I am financially responsible for all charges whether or not paid by my insurance, including all deductibles as determined by my insurance company. The current fee schedule is:

Initial Intake (CPT 90791)	$ 200.00 (45-50 Minute Session)
Psychotherapy (CPT 90834)	$ 140.00 (45 Minute Session)
Psychotherapy (CPT 90837)	$ 175.00 (60 Minute Session)
Family Therapy (CPT 90847)	$ 150.00 (45 Minute Session)
Family Therapy w/o Pt (CPT 90846)	$ 150.00 (45 Minute Session)

I also realize that if I cancel my appointment without a 24-hour notice I am responsible for the fee stated by my therapist.

_____ _____

Signature of subscriber, or insured, or of responsible party — Date

I, the undersigned, have insurance coverage with:

_____, _____

Name of Insurance — Address of Insurance Company

_____Phone#_____

and hereby agree to financial arrangements. Should the stated insurance coverage be less than the agree upon fee for service, I assume full responsibility for all charges.

Effective Date of Insurance: _____

Calendar Year Deductible: _____ Met? ____Yes ____No

Insurance Coverage Per Session: _____

Client Co-Payment Responsibility Per Session: _____

Maximum Allowable Benefit Per Year:_____

Behavioral Health Care Company Name and Address: _____

_____ Phone # _____

_____ _____

Signature of subscriber, or insured, or of responsible party and/or client — Date