Health Insurance Authorization Form

Please complete this form to authorize Thrive Therapeutic Services to bill your health insurance for therapy services.

Client Information

- **Full Name:** _____
- **Date of Birth:** _____
- **Address:** _____
- **Phone Number:** _____
- **Email Address:** _____

Health Insurance Information

Primary Insurance:

- **Insurance Provider:** _____
- **Policy Holder's Full Name:** _____
- **Policy Holder's Date of Birth:** _____
- **Policy Number:** _____
- **Group Number:** _____
- **Customer Service Phone Number (Back of Insurance Card):**

  _____

Secondary Insurance (if applicable):

- **Insurance Provider:** _____
- **Policy Holder's Full Name:** _____

Health Insurance Authorization Form

- **Policy Holder's Date of Birth:** _____
- **Policy Number:** _____
- **Group Number:** _____
- **Customer Service Phone Number (Back of Insurance Card):**

  _____

Authorization

I, the undersigned, authorize Thrive Therapeutic Services to bill my health insurance for therapy services provided to the client named above. I understand and agree to the following:

1. **Release of Information:** I authorize the release of any information necessary to process and adjudicate claims, including diagnosis and treatment information.
2. **Verification of Benefits:** I understand that Thrive Therapeutic Services may verify my insurance benefits to determine coverage and financial responsibility.
3. **Assignment of Benefits:** I request that payment of authorized insurance benefits be made on my behalf to Thrive Therapeutic Services for any services provided. I understand that I am financially responsible for any deductibles, co-pays, or services not covered by my insurance.
4. **Changes to Insurance Information:** I will promptly inform Thrive Therapeutic Services of any changes to my insurance information, including changes in coverage, policy number, or contact information.
5. **Responsibility for Non-Covered Services:** I understand that I am responsible for payment of services not covered by my insurance, including but not limited to non-covered services, deductibles, and co-pays.

Client's Signature: _____ **Date:** _____