Richard Sladich, MS, LCMHC

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)

_____ ☐ home ☐ mobile ☐ work ☐ other
Phone Number

SIGNATURES

I have read, understand and agree to Richard Sladich, MS, LCMHC's Professional Disclosure Statement. I understand that I am responsible for payment of any and all services rendered by Richard Sladich, MS, LCMHC 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, LCMHC 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, LCMHC. I understand that I am responsible for payment of services rendered to me by RICHARD SLADICH, MS, LCMHC 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, LCMHC whenever there are changes in my/the client's health condition or health plan coverage.

_____
Signature (for insurance billing) Date