

Danielle M. Greene MA, LMFT #97554

Licensed Marriage Family Therapist

(707) 840-4672 539

G St. #108 Eureka, CA 95501

If you would like to verify your insurance eligibility please fill out and submit the following information:

Patient's Full Name:

Date of Birth: (MM-DD-YY):

Insurance Company:

Member ID#:

Telephone Number:

E-mail Address:

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Credit Card/Debit Payment Agreement

To facilitate compliance with the insurance billing process I am providing the following credit or debit card to be kept on file. I understand that without this completed form my insurance will not be billed and I will need to pay for services in full at the time they are rendered. This form is valid through the expiration date on the card, unless I cancel the authorization through a written notice to this organization.

Client Name: _____ **(PLEASE PRINT)**

I authorize the administrative staff to charge the listed credit card for future services provided by the therapist named above starting _____ (date). This includes billing me for unpaid copay's, deductibles and appointments missed or not canceled with 48 hours' notice.

Credit Card Information (ALL INFORMATION IN THIS SECTION IS REQUIRED)

Card Number: _____ - _____ - _____ - _____

Expiration Date: _____/_____ Security Code: _____ (3 digit code on the back of card)

Billing Street Address: _____

Billing Zip Code: _____

Name as is appears on Card: _____

(Please Print)

Client Signature: _____ Date: _____

Email Address to Send Receipt To: _____