Revisions Counseling Services, LLC
Medical Release Form for Insurance Billing

Patient Information

Patient Name:		**DOB:**
Address:		
City:	**State:**	**Zip:**
Phone:	**Email:**	
Emergency Contact (name and number):		
Employer:		

Insurance Information:		
Employer: **Insurance Company**:		
Insurance Address:		**Phone Number:**
Member ID #:	**Group#:**	
Deductible:	**Amount of Deductible met:**	
Co-Pay:		
Diagnosis:		

By signing below I agree that all of the information I have provided is true and I give permission to Revisions Counseling Services to release medical records to my insurance company for the purpose of receiving payment. Under the circumstance that my insurance company does not pay for my scheduled office visits I will be responsible for payment directly to my Therapist, Regina Thomas, LCPC at Revisions Counseling Services.

_____Date ____/___/___
Patient Signature

_____Date ___/___/___
Therapist Signature