AUTHORIZATION FOR INSURANCE

Insurance Provider: ____

Member ID: ____

Policy Group: ____

Policy Holder: ____

Relationship to Policy Holder: _______________________________

Policy Holder DOB: ____

Address of Policy Holder: ____________________________________

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Acknowledgement

I authorize Ally Mental Health to release information to the insurance companies provided on this form in order to submit insurance claims on my behalf. This authorization extends to the extent necessary to obtain payment for the services provided to me, and includes authorization to release information about mental health, substance use, or HIV diagnoses as required. In consideration of the services provided to me, I assign all benefits to Ally Mental Health if accepted, and authorize my insurance companies, Medicare, or other third-party payers to make payments directly to Ally Mental Health and its affiliates. I understand that I remain responsible for all amounts due by me, including (but not limited to) copays, coinsurance, deductible amounts, and all services not covered by my insurance plan (including those for which I fail to obtain prior authorization), and mutually agreed-upon services or fees that are deemed not medically necessary.

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Signature Date