Client account Number:_____

Insurance Authorization

Client Name:_____

Primary Insurance Company: _____ ID #:_____

Insured's Name:_____ Relationship to client: _____

Insured's Birth date: _____/_____/_____ **Client's Birth Date: _____/_____/_____**
If different

Client's mailing address:_____

City:_____ State: _____ Zip:_____

Client's Phone #:_____

Coverage for Therapy/Counseling: Yes____ No____ **Co-pay amount: $_____**

Benefit Assignment & Records Release

This signature authorizes Wayne McAuliffe, M.S. or Laura McAuliffe, M.S. to release any necessary information regarding my medical/psychological treatment to my insurance company for the purpose of insurance collection. This signature also authorizes payment of medical benefits to be paid directly to Wayne McAuliffe, M.S. or Laura McAuliffe, M.S.

_____ _____
Patient Signature or Legal Guardian Date