INSURANCE BILLING CONSENT

KATHY WAGNER COUNSELING SERVICES, LLC

111 Petrol Point Drive, Suite 102
Peachtree City, GA 30269

CLIENT INFORMATION:

Name ______________________ (Print name) SS# ______________________

Address ______________________ DOB ______________________

______________________ SEX: M ____ F ____

Home # ______________________ Cell # ______________________

Employer ______________________

RESPONSIBLE PARTY:

Name ______________________ (Print name) SS# ______________________

Address ______________________ DOB ______________________

______________________ Relationship ______________________

Home # ______________________ Cell # ______________________

Employer ______________________ Work # ______________________

PRIMARY INSURANCE: *(Write secondary insurance information on back of page.)*

Insurance ______________________ (Name of company) Phone # ______________________

Address ______________________ Policy # ______________________

______________________ Group # ______________________

Insured Name ______________________ Insured DOB ______________________

I authorize KATHYWAGNER COUNSELING SERVICES, LLC and/or NETCLAIMS MEDICAL MANAGEMENT billing service to file and receive payment of medical benefits. I understand that I am responsible for payment. I consent to the release of any medical and psychological information necessary to process my claims. I agree this authorization will cover services rendered until this authorization is revoked. I agree that a copy of this authorization form may be used in pace of the original. **I understand that there will be a charge for all missed appointments and appointments not cancelled within 24 hours of appointment time.**

______________________ ______________________

Client Signature Date