PLEASE NOTE ALL 3 AREAS MUST BE SIGNED IN ORDER FOR OUR OFFICE TO BE ABLE TO BILL YOUR INSURANCE/ EAP COMPANY

AUTHORIZATION TO BILL INSURANCE

I,_____, hereby give my

consent for Radka Chapin Counseling, PLLC, to bill my insurance/ EAP

company _____ for services
(Name of Insurance Company)
rendered to me by the above mentioned health care provider.

PATIENT SIGNATURE:_____

ASSIGNMENT OF BENEFIT

I authorize the above mentioned insurance/ EAP company to pay medical benefits directly to the above

mentioned health care provider.

PATIENT SIGNATURE:_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Radka Chapin Counseling, PLLC, to release necessary medical

information to the above mentioned insurance/ EAP company and/or to their designated managed

care company, _____, as is required by my
(Name of Managed Care Company)
insurance company to process my insurance/EAP claims.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

Date: _____

PATIENT SIGNATURE:_____

DOB:_____