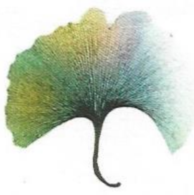

Emily Pimpinella, Psy.D.
Clinical Psychologist

Authorization and Insurance Release Form

Identifying Information

Legal Name: ____

Date of Birth: ____________________

Address: ____

____

Primary Phone #: ____________________ ☐Cell ☐Home ☐Work ☐Other: __________

Secondary Phone #: ____________________ ☐Cell ☐Home ☐Work ☐Other: __________

Employer: ____

Insurance Information

Name of subscriber (if different from name above): ______________________________

Subscriber's Address: ____

Subscriber's DOB: ____________________

Name of Insurance: ____

Identification/Agreement/Policy #: ____________________ Group #: ____________________

By signing this document, I am allowing Emily Pimpinella, Psy.D., to release any medical or other information necessary in order to process my insurance claims. I hereby authorize Dr. Pimpinella to apply for benefits on my behalf for covered services rendered by her or by her order. I also authorize and request that payment of medical and government benefits for services rendered by Dr. Pimpinella be paid to her directly. I understand that I will be personally responsible for any amount denied or any remaining amount owed for services partially covered by my third-party payer/insurer. I permit a copy of this authorization to be used in place of the original. By signing below, I acknowledge that I understand that Dr. Pimpinella may need to release my diagnosis, dates of service, treatment goals, treatment notes, and other information in order to receive reimbursement.

______________________________ ____________________
Signature of Client/Client's Representative Date

______________________________ ____________________
Printed Name of Client/Client's Representative Relationship to Client

213 North Aurora Street
Ithaca, NY 14850

Phone: 607-273-1083
Fax: 607-273-1183