**INSPIRING HEALING AND HOPE COUNSELING AND DEVELOPMENT CENTER, LLC**

**44 Darby’s Crossing Drive, ste 202, Hiram, GA 30141**

**404-907-6635**

**FINANCIAL FORM**

**INSURANCE INFORMATION ~Please provide insurance card~ Skip if self-pay**

Policyholder’s Name Policyholder’s SSN: - - Date of Birth / / Primary Insurance Co. Name

Insurance Company’s Customer Service Phone # \_ Policyholder’s Employer:

Insurance ID #\_

Group #

Co-pay $

Deductible? � Yes � No Amount $

Authorization Required? � Yes � No Authorization #

Number of Sessions Authorized

Maximum Number of Sessions Allowed Per Year

Is the patient covered under a secondary insurance policy? Yes No

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (client or legal guardian) authorize Inspiring Healing and Hope Counseling and Development Center, LLC, or any holder of medical information about me to release to my insurance company or its representative, any information needed concerning the examination or treatment rendered to me that is necessary to process the insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to be paid directly to LaShawn Faison-Bradley/ Inspiring Healing and Hope Counseling and Development Center, LLC in such amount as my benefits allow. This authorization is effective until terminated in writing by the client or their guardian.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Guardian Signature Date