Blissful Path Therapy

Follow your bliss

INSURANCE AUTHORIZATION FORM

Client Name: _____ Gender: 0Male 0Female

Date of Birth:_____ Client SS#: _____

Insurance Carrier: _____

Client Insurance ID: _____Group #: _____

Client Relationship to Insured: _____

Insured Name: _____ Gender: 0Male 0Female

Date of Birth:_____ Insured SS#: _____

Address: _____

City, State, Zip: _____

Insured Employer: _____

Insurance Carrier: _____

Insured Insurance ID: _____Group #: _____

Blissful Path Therapy Services, LLC will bill most insurance carriers for you if proper paperwork is provided to us. Any outstanding balances, co-payments and deductibles are due prior to you appointment. Since your agreement with your insurance is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you.

TO SUBMIT CLAIMS TO INSURANCE: I hereby authorize Blissful Path Therapy Services, LLC to apply for benefits on my behalf for covered services rendered by the practice, and request that payments are made directly to Blissful Path Therapy Services, LLC. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information, for any related claim. I permit a copy of this authorization to be used in place of the original. I understand and agree that all co-payments are due at the time of service. I have read the above financial policy for payments for professional fees and understand and agree to pay for services not covered by my insurance company for any reason.

Signature: _____ Date: _____

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