INSURANCE INFORMATION

	Primary	**Secondary**
Name of Insurance Comp	_____	_____
Policy Number	_____	_____
Group Name	_____	_____
Group Number	_____	_____
Name of Insured	_____	_____
Insured D.O.B	_____ _____	_____
SS# of Insured	_____	_____
Employer of Insured	_____	_____

PLEASE READ CAREFULLY

The patient is responsible for ALL fees, regardless of Insurance Coverage. All charges are due at time of service unless other arrangements have been made in advance. I understand that I am responsible for any amount NOT covered by insurance. I hereby authorize payment directly to Therapy Center Valdosta all insurance benefits not to exceed the Center's regular charges. I hereby authorize Therapy Center Valdosta to release the information needed to any physician and/or third party responsible for payment of such services.

APPOINTMENTS- Schedule, change and cancel appointments through the office manager. If you find that you cannot keep your appointment, notify our office as soon as possible. A charge may be made for all appointments not cancelled 24 hours in advance, and this charge will be the responsibility of the patient.

AUTHORIZATION FOR TREATMENT/ACKNOWLEDGEMENT OF PATIENT RIGHT

I, the undersigned, hereby request treatment by the staff of Therapy Center Valdosta. I understand that this office does not discriminate on the basis of race, creed, religion, age, sex, political affiliation, physical or mental handicap. I realize that such treatment will be conducted by a treatment team which may include therapists, social workers, psychologists, medical doctors and under appropriate supervision. In addition, I understand that I have rights as a patient and realize procedures exist to file any grievances that may arise during treatment. This authorization will continue in effect until revoked in writing.

Notice of Privacy Practices

This _____Day of _____200___

_____ _____ _____

(Patient's signature or legal guardian) (Date) (Staff's signature)