Rachel Benson Monroe, LMHC

License #9388 •50/26 Trapelo Rd. Belmont, MA 617-942-1065 •RachelBMonroeLMHC@gmail.com

Name: _____ Date: _____

Insurance Coverage: _____

Policy # or Member ID: _____

Co-pay amount:_____

Policy Holder info

Name: _____ DOB:_____ Age_____

Relationship to subscriber:_____Phone_____

Address:_____Zip:_____

All patient insurance obligations (such as deductible and copayments) are due on the date of your appointment. I hereby authorize Rachel Benson Monroe, LMHC to release any information in the course of my treatment to be used for the sole purposes of insurance collections and other medically necessary circumstances as mandated by State or Federal Law. I also understand that I will be charged $75 should I not provide sufficient notice (24 hours) before cancellation of an appointment as dictated by office policy. In circumstances allowed by law and necessary to complete my treatment, the office will obtain prior authorization from me before releasing any medical or other billing related information. Treatment services may be billed electronically to my insurance company using the highest level of data security. I understand that I am responsible for understanding the benefits and limitations of my plan. I have the right to view any information that this office has received regarding my medical history and billing records given reasonable advance notice. I will inform the office if I have any concerns regarding my privacy, billing records, or any other information. hereby authorize my insurance benefits to be paid directly to Rachel Benson Monroe, LMHC for the behavioral health services rendered.

It is the patient's responsibility to determine if their insurance will cover therapy services. If services are not covered by the patient's insurance, the full fee must be paid to the provider.

Client Signature _____ Date_____