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Signature on File

Community Counseling Services

Rev 01/17

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Case Name ______________________________

Case Id # ________________________________

Date ______________________________

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NAME OF INSURED: Last_________________________, First _________________________.

NAME OF PATIENT: Last _________________________, First __________________________. *(If other than insured)*

I understand and agree that I am responsible for the payment of any and all charges incurred as a result of this or any subsequent office visit(s). I also understand and agree to accept responsibility for payment of any and all claims should my insurance carrier and/or other payers deny all or part of a claim.

I understand and agree that all insurance deductibles and any incurred expenses not covered by the insured's health carrier must be paid for at the time of services.

I hereby authorize payment directly to Community Counseling Services, for any services rendered to me by any Community Counseling staff or any authorized agents. I authorize the release of all medical information to the insured's health insurance carrier that is: 1) acquired in the course of my examination or treatment and 2) which may have a bearing on the benefits payable under this or any other plan that provides benefits or services. I authorize Community Counseling Services or any of their authorized agents to assist me in obtaining payment from my health insurance companies.

I authorize a copy of this "Signature on File" form to be used in place of the original and that this copy may be used on all my insurance submissions.

____ ____________________

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE *DATE*

~ This Authorization is Good for one year~
(or updated if any of the above changes)

My signature below gives Community Counseling Services consent to bill or retroactively bill for all covered services within the signature date and the release of any medical records information needed to determine payment for these services by any of my payer sources.

Individual's Signature ____ Date ________________________

FOR OFFICE USE ONLY: When the authorization is obtained, the provider should indicate "SIGNATURE ON FILE" in the patient's signature space on the claim form. If you are submitting a signed claim form or if you are maintaining signature on file, the recipient's signature requirement remains the same. Be sure the recipient signs his/her name. If the recipient cannot write his/her name, he/she should sign by a mark and have a witness sign the recipient's name and indicate by whom the name was entered. If the recipient is a minor or otherwise unable to sign, any responsible person, such as a parent or guardian, must enter the recipient's name and write "By", sign his/her own name and address in the space, show his/her relationship to the recipient and explain briefly why the recipient cannot sign.