Art of Therapy Center
A holistic approach to therapy with families.

Authorization for Filing Insurance for services

I, _____, hereby authorize the release of any medical or other information to process insurance claims. I authorize the payment of medical benefits to Art of Therapy Center.

Responsible Party/ Guardian Information:
Name of person financially responsible: _____
Address: _____ City _____State ____ Zip _____
Telephone number: _____ Social Security Number_____
Relationship_____

Insurance Information:
Name of Insurance_____Group Number_____
ID# _____ Name of Person Insured _____
Client's relationship to insured:____Self ____Child ____Spouse Insured's Date of Birth_____ Sex: ____Male ____Female
Employer _____
Insured's Social Security Number _____
Effective Date of Policy _____

_____ _____
Signature of Client or Legal Guardian Date