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

2907 Rousseau Ct. Gastonia, NC 28054
117 West Marion St. Shelby, NC 28150