**INSURANCE AUTHORIZATION AND ASSIGNMENT**

I hereby authorize Jenica Polakow, LCSW to furnish information needed to bill the above-named insurance carriers on my behalf, including information concerning my illness and treatments.

I hereby authorize the above-named insurance companies to pay directly to Jenica Polakow, LCSW, all payments for medical services rendered to me.

I agree to accept responsibility for any portion of my bill that my insurance does not cover. I acknowledge that accounts are due and payable within 30 days and that failure to make monthly payments towards my account may result in a service charge and or further collection action.

**Patient Signature          Date**

**WELCOME AGREEMENT & HIPAA RECEIVED**

I have read and understand the information outlined and wish to receive counseling with Jenica Polakow, LCSW at the agreed upon fee of $120 per session.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name   Patient Signature Date**

**FOR OFFICE USE ONLY:**

Name of Representative releasing information**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date and time contacted\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In-Network or Out of Network? Co-pay: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the Deductible\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount met? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How many sessions per calendar year? \_\_\_\_\_\_\_\_\_