North Oakland
Family Counseling Center P.C.
6887 Dixie Highway – – Clarkston, MI 48346
(248) 620 -1019 – Fax: (248) 620-1026

SIGNATURE ON FILE AUTHORIZATION
(FOR INSURANCE CLIENTS ONLY)

I,_____, request payment of authorized medical benefits to be paid directly to **North Oakland Family Counseling Center** on my behalf.

I authorize the release of any information deemed necessary by my therapist/doctor to process this claim. Claims submitted by my therapist/doctor shall state, A signature on file in the space provided for my signature on the insurance form. A copy of this will be sent with the first billing only.

_____ _____
Date Insured Authorized Signature

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the client, to please check with your insurance company prior to any therapy. It is your responsibility to know your individual coverage. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. Please remember your insurance policy is between you and your insurance company and not with the insurance company and your doctor/therapist.

_____ _____
Signature Witness

_____ _____
Date Date