Lauren Dahl, LCSW

AUTHORIZATION TO BILL INSURANCE

I, _____(client name), DOB_____, hereby authorize Lauren Dahl, LCSW, to bill my insurance company/employee assistance program _____ for my treatment. My Subscriber/Member ID is _____. My Group Number (if applicable) is _____. The phone number to verify mental health benefits is _____. The primary subscriber (if not myself) is _____, DOB _____, whose address (if different from mine) is _____

_____

and who is employed by _____.

I understand that my diagnosis will be provided to my insurer. I understand that the insurance company may request additional clinical information regarding my treatment progress in order to authorize sessions and/or payment. I also understand that they may request copies of my records as part of a Quality Assurance audit with which Lauren Dahl, LCSW, is required to comply in accordance to her contract with the above-named insurance company. I authorize Lauren Dahl, LCSW, to provide all such information as necessary.

_____ _____

Client or Guardian's Signature Date

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