Consent for Release of Information to an Insurance Company

1. I grant Vicki Eaton, LCSW (Vicki L. Eaton, PC) permission to bill my insurance company for services received. I understand that she may make use of a billing service with expertise in medical billing, and I give her permission for that also.
2. I permit Vicki Eaton, LCSW (Vicki L. Eaton, PC) to release my name, address, date of birth, diagnosis, treatment plans, and services rendered whenever required by my insurance company in order to process the claims.
3. I am aware of my right to review the information released, and understand that signing this form is not a required condition of treatment. I further understand that I may cancel this permission at any time.
4. I understand that every insurance company requires a medical diagnosis before they will reimburse for any therapy services, and as part of the process of filing for reimbursement, Vicki Eaton, LCSW (Vicki L. Eaton, PC) will be submitting a clinical diagnosis for the person identified as the client on the insurance claim form. This diagnosis will be formulated according to the rules and criteria of the **Diagnostic and Statistical Manual of Mental Disorders, 5th Edition** of the American Psychiatric Association (or whatever the latest edition is at the time of billing).
5. I understand that I am fully responsible for my medical bill with Vicki Eaton, LCSW (Vicki L. Eaton, PC) that insurance does not cover, including situations in which the insurance company states that they will make payment either to Vicki L Eaton or to myself, and then at a later time they refuse to do so. The exception to that is if my insurance says I owe nothing.
6. This release will be considered to be in effect for 365 days from the date signed.

Signed ____ Date ______________