

Lola R. Georg
Licensed Professional Counselor

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Information and Authorization to Bill Insurance Company

Client Name:		DOB:	Gender:
Client Address: _____, _____, _____			
Street address		City	State Zip code
Cell Phone:	Home Phone:	Relationship to insured:	
Policy Holder Name (if different than client):			DOB:
Policy Holder Address:			
_____		_____	_____
Street Address		City	State Zip Code
Cell Phone:	Home Phone:	Work Phone:	
Insurance Company:			
Policy #:			Behavioral Health Phone #:
Deductible: \$	Deductible met: \$	Co-pay: \$	Authorization needed after session #:
Address for primary insurance company for filing claims by mail:			
_____		_____	_____
Street Address		City	State Zip Code
Name of person responsible for payment if not client:			
Address: _____			
Street Address		City	State Zip Code
Phone:	Email:		
Is treatment related to an auto accident?		Is treatment related to a work accident?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please read and initial:

____ I hereby acknowledge that I give Lola Georg and Georg Associates permission to bill my insurance company. I understand that I am responsible for payment should my insurance company declare that my treatment is not medically necessary, refuses to authorize treatment and/or is not covered under your policy.

____ If my insurance is a PPO rather than an HMO, I agree to pay Lola Georg or Georg Associates, directly for each session. Upon request, Lola Georg, will write a receipt for you, the client, to submit to your insurance company for reimbursement.

____ If I do not use my current insurance now but choose to use it in the future, I will not ask Lola Georg or Georg Associates to submit for sessions already received.

____ I understand that if I have any questions regarding the use of my insurance, I can contact Lola Georg, at (484)324-8370 or at LolaGeorgLPC@gmail.com.

Signature of Client

Date