# FAMILY GUIDANCE CENTER
## INSURANCE AUTHORIZATION AND RELEASE OF INFORMATION

I, _____, authorize Family Guidance Center to release information related to
*Client's Name or Legal Guardian Name*

the payment of insurance benefits to _____, _____
*Insurance Company Name* *Member ID*

I request that payment of all authorized insurance benefits be made on my behalf to Family Guidance Center.:

I agree to pay for services according to the following fee schedule of Family Guidance Center:

Psychosocial Evaluation (Intake) .....….$150.00
Individual or Family Session 45 to 75 Minutes. $135.00
Individual or Family Session 75+ minutes……. $165.00
Group Counseling – 1 Hour Session.....….$ 60.00
Group Counseling – 1 ½ Hour Session.....….$ 90.00
Group Counseling – 2 Hour Session.....….$120.00
Group Counseling – 2 ½ Hour Session.....….$150.00
Psychiatric Evaluation .....….$200.00
Medication Review Visit .....…. $ 70.00

I understand that my insurance company is billed according to the above fee schedule. **In the event insurance does not cover services, I AM RESPONSIBLE FOR PAYMENT.**

I permit a copy of this authorization to be used in place of this original.

I understand that the release of drug and alcohol treatment information must be limited to or in accordance with 4PA code subsection 255.5 (b).

I understand that any restriction or revocation of this consent may result in the inability for Family Guidance Center to continue to provide further treatment to me. Further, I understand that Family Guidance Center may refuse to treat me if I, or my authorized representative, do not sign this consent, except to the extent that such treatment is required by law. I understand that I can revoke my authorization at any time. This right and your other privacy rights are contained within our notice of privacy practices.

This authorization to release confidential information will remain valid for up to 365 days from the date of my signature or until all billing issues are resolved.

_____ _____
*Client Name* *Date of Birth*

_____ _____
*Client's Signature* *Date*

_____ _____
*Witness* *Date*

* _____ _____
*Responsible Party if Client is a minor/dependent* *Date*

**Do not use this signature line for Substance Abuse Treatment Clients.*
Client □ ACCEPTED □ REFUSED a copy of this Release.