Muriel S. McClellan, Ph.D.

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Insurance Information and Release Form

Client's Name:_____ **Today's Date**:_____

Member Number_____ **Date of Birth**:_____

This form must be completed if you want us to use your insurance benefits for the treatment of a mental disorder. Dr. McClellan's fee will be changed to the negotiated fees for these insurance companies only. If the services are not covered by the plan, then the fee will be changed back to the regular fee. These contracted insurance plans require that Dr. McClellan submit the insurance forms directly to them. If you consent to use your coverage for this service, your insurance company will be allowed to have access of your medical records and mental health information.

1. Is Pre-certification Necessary? Yes ( ) No ( ) Authorization #_____
2. Name of Primary Insurance Company _____
   ID Number_____ Group Number _____
3. Secondary Insurance Company _____
   ID Number_____ Group Number _____
4. Name Policy Is Under (if other than yourself): _____
   Their Date of Birth: _____
   Your Relationship to Them ( ) Spouse ( ) Parent/Child ( ) Other _____

Release: I hereby grant permission for Dr. McClellan to disclose information regarding this treatment to my insurance company, managed health care network and/or my employee assistance program. This may be done to assist in the management of the care and for the evaluation and administration of my claims, as appropriate.

Assignments: I authorize payment of medical benefits to be made directly to Dr. McClellan for services rendered.

Responsibility: I understand that I am responsible for the co-payment amount and any deductible amount. I understand that if I do not provide the correct information for insurance billing, (including proper authorizations required by your plan) I will be responsible in full for services rendered at Dr. McClellan's regular rate. If, for any reason, the request for payment is denied by my insurance company or the services are not covered or paid for by my insurance company, I agree to make arrangements for prompt payment for services rendered. I am aware that insurance companies do not provide reimbursement for canceled sessions. **I will be responsible, at Dr. McClellan's regular rate, for any appointment for which I do not show, or have not canceled within 48 hours.**

Signature: _____ **Date**: _____