**Insurance & Payment Authorization Form**

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Insurance Company Information** |
| Insurance Company: ☐ Anthem BCBS ☐ Aetna ☐ Cigna ☐ Optum/United Healthcare  □ Oscar Health □ Optima  □ Other |
| Policyholder Name (as shown on card): |
| Relationship: □ Self □ Parent □ Other (specify): |
| Policy #: |
| Group #: |
| Effective dates: |

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize **Bolden Therapy & Wellness, LLC** to bill my insurance company above for agreed therapeutic services. I understand that my information will be saved to file for future transactions on my account.

|  |
| --- |
| **Credit Card Information** |
| Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX  □ Other |
| Cardholder Name (as shown on card): |
| Card Number: |
| Expiration Date (mm/yy): |
| Cardholder ZIP Code (from credit card billing address): |

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize **Bolden Therapy & Wellness, LLC** to charge my credit card above for agreed therapeutic services. I understand that my information will be saved to file for future transactions on my account.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client or Parent/Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Date