**Outside the Lines Counseling, LLC**

**Amy Heilman, LCSW-C, Therapist**

**22 W. Padonia Road**

**Suite A-203**

**Lutherville, Maryland 21093**

**410-245-9722**

**Financial Responsibility and Insurance Release Form**

I certify that I, or my dependent(s), have insurance coverage with\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I assign directly to Outside the Lines Counseling, LLC, all insurance benefits payable for services rendered. I understand that I am responsible for fees incurred for services not paid by my insurance company, due to my deductible or **failure to call and get authorization prior to the visit (if required)**.

I hereby authorize Outside the Lines Counseling, LLC to release information to the above -mentioned insurance company, and their agents, in an effort to determine insurance benefits and obtaining payments. I authorize the use of my signature on all insurance claim submissions.

**I understand that my appointment time is reserved for me and that I will be charged full fee for any appointment missed without 24 hours notice, except in cases of true emergencies.**  I understand that if I am using insurance, if I miss an appointment, my insurance will not cover that appointment and I will be responsible for paying the full fee.

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist Signature

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