Sally Kennedy, Ph.D., LLC
Licensed Psychologist
1160 Milledge Ave.
Suite 130
Athens, GA 30605

706-850-9640; 888-548-1270 (fax)

Patient Name: _____

DOB: _____

Phone: _____

INSURANCE RELEASE AUTHORIZATION

When you seek treatment with me, you have the option of either paying a direct fee for service or using your insurance. I, or my billing manager, will file insurance claims on your behalf. Filing such claims often involves sharing your diagnosis code, the date of your appointment, and other personal information (i.e. name, address, DOB, SSN, etc.). Without such information, insurance will not accept the claim and deny it.

If insurance refuses to pay for your treatment, ***it is your responsibility to pay any and all charges not covered***. Please note that insurance is also bound by confidentiality, and that any information shared about you will remain private. Once information is submitted to insurance, it is your insurance company's responsibility to maintain confidentiality. I am no longer responsible for the protected health information submitted to insurance on your behalf.

Insurance companies also have the right to audit your treatment record. I will attempt to inform you of a request to audit your treatment record. I must comply with such requests for insurance to reimburse for services provided. If the insurance denies coverage after an audit, you are responsible for all charges per appointment.

Your signature below means you agree and consent to my sharing necessary information with insurance. You may revoke your consent in writing at any time. Please be aware, however, that should you revoke your consent, we can no longer file claims and you will be charged the full, direct service fee for each session. Any revocation will be in effect with the exception of claims or information that has already been submitted per your authorization.

I, _____, authorize Dr. Sally Kennedy, LLC and her representatives to file claims with my insurance company, with the consent to release any information necessary for claims (i.e. diagnosis codes).

Name _____ DOB _____

Member ID _____ Group # _____

Name of Policy holder _____ DOB _____
(if someone other than client)

Address of Policy holder _____

_____

I understand that my insurance may not cover psychological treatment and that I am responsible for any and all charges not paid by my insurance. I also understand that failure to pay any outstanding balances within 90 days will result in a 3% interest fee per month on any outstanding balance. Dr. Kennedy has the legal right to submit outstanding balance to outside agencies for help in collections.

This authorization will expire one year following the date of signature, unless revoked in writing prior to that date.

Signature: _____ **Date:** _____

*Note below if Authorization is given on this patient's behalf due to being a minor or unable to sign for the following reasons:

Signature: _____ Date:_____

*Legal Guardian/Personal representative