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**Katherine Ward, LCSW**

*Psychotherapy/EMDR*

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**Insurance Authorization Form**

I hereby authorize Katherine B. Ward, LCSW, to apply on my behalf for covered services

rendered by her. I request that payment from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

be made to Katherine B. Ward, LCSW. I certify that the information I have reported regarding my insurance coverage is correct. I further authorize the release to the above-named insurance company any information, including medical information, that is necessary for the authorization of benefits.

This authorization of payment may be revoked by me or my insurance company in writing at any time.

I further understand that I may be billed for appointments that I cancel without 24-hours’notice (emergencies and illness excepted), and that I am responsible for all charges whether or not they are paid by the above-named insurance company.

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

 Signature

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

 Print Name

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

 Date