Sarah Horvath, LCSW

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Office Space only DX_____

In the event we file your insurance claim, by signing below, you authorize the release of medical information requested by the insurance company and you authorize payment of insurance benefits directly to Sarah Horvath, LCSW

Signature_____ Relationship to client _____Date_____

Client (Adult/Child) _____DOB_____Age_____

Address_____ City/ Zip_____

Client Phone: Cell#_____ Email_____

Occupation/grade_____Employment/School_____DL#_____

Household Members: Name M/F Relationship to client Date of birth/Age

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Spouse/partner/Parent/Guardian/other information if applicable:

Name_____ Relationship _____Cell_____

Address_____

Email_____DOB_____Age____DL#_____

Name_____ Relationship_____ Cell_____

Address_____

Email_____ DOB_____ Age____ DL #_____

Emergency Contact_____Phone_____Relationship_____

If you are private pay; you are indicating and are agreeing to the following:

1. You do not have insurance coverage.
   AND/OR
2. Have insurance coverage but choose not to use it, and, understand that in doing so you are waiving any right to reimbursement for my services.
   AND/OR
3. You have insurance coverage but understand that my services are not covered by the plan.
4. You understand that we will not file insurance for you and that you will not hold Sarah Horvath, LCSW liable for any insurance benefits.

Private Pay_____

Our office will file your insurance unless you have chosen private pay

Primary insurance_____ Secondary insurance_____

A COPY OF YOUR INSURANCE AND DRIVERS LICENSE IS REQUIRED