Tammy L. Sausa, LCSW
132 Midland Avenue
Suite A
Garfield, NJ 07026
973-340-1500
www.atherapylifecenter.com
tammysausa@atherapylifecenter.com

Insurance Information and Authorization Form

Client's Name: _____ D.O.B_____

Policy Holder: _____D.O.B: _____

Address: _____

Telephone Number: (___) _____

Name of Employer Associated with Insurance: _____

Insurance Program: _____

Identification Number: _____

Group Number: _____

Insurance Phone Number: _____

Claim Submission Address: _____

Out of Network Deductible: _____

Other Insurance Information: _____

_____

Authorization To Release Information And Assignment Of Benefits

I understand it is my responsibility to be educated about the benefits and limitations of my insurance policy. I understand that in the event my insurance policy does not pay for services rendered to me, I am financially responsible for payment for those services. I authorize the release of any medical information necessary to process my claims. I permit a copy of authorization to be used in place of the original. I have discussed payment and reimbursement options with Tammy L. Sausa, LCSW. I understand that if I am unable to pay for psychotherapy services at my appointment, I will forward the balance due from my health insurance company upon receipt. Furthermore, I understand that in some cases, payment from my insurance company may be made directly to Tammy L. Sausa, LCSW.

My signature below indicates that I have read and accepted the information contained in this notice

Name: _____ Date: _____