Mielke & Weeks Psychological Services

Insurance Company Billing Authorization

I, _____, authorize **Mielke & Weeks Psychological** Services and their billing company associates to release information to my insurance company as required by my insurance company and deemed necessary for the processing of claims related to the specific services rendered by my service provider.

I fully understand that I am responsible for any deductibles or co-pays as required by my insurance plan coverage. I agree to pay my portion of the fees owed either at the time of services rendered or upon receipt of billing received from Mielke & Weeks Psychological Services.

In the event that my insurances company does not pay for the services rendered, I agree to pay for all sessions at the stated fee for service.

Insurance Company:_____
I.D. Number:_____
Patient D.O.B._____

Signed:_____
(Patient) (Parent if under age 18) (Date)

_____
(Provider) (Date)