F. Michael Montgomery, LCSW, LMFT

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Therapy for the heart, mind, body and spirit in a safe and healing setting

Insurance Information and Authorization

Insurance Company Information

Name of Insurance: _____ Subscriber's Name: _____

Subscriber's Social Security #: _____ Relationship to Client: _____

Subscriber's Date of Birth: _____ Subscriber's Insurance I. D. #: _____

Subscriber's Group #: _____ Name of Subscriber's Employer: _____

Your Social Security #: _____ What is the authorization #: _____

How many sessions have been authorized? _____ What is your co-pay? _____

Authorization To Release Information

I authorize the mutual release of any information necessary to process my insurance claim between my insurance company and F. Michael Montgomery. A copy or fax of this authorization is as valid as the original.

_____ _____

Signature Date

_____ _____

Signature Date

Authorization Of Insurance Benefits

I authorize the payment of insurance benefits for services rendered during the course of treatment to be paid directly to F. Michael Montgomery. A copy or fax of this authorization is as valid as the original.

_____ _____

Signature Date

_____ _____

Signature Date