# Atlanta Consulting & Psychological Services, LLC

Psychological Services for Families, Individuals & Couples

INSURANCE INFORMATION

Insurance: Yes [ ] No [ ]

Name: _____

Insured Address: _____ Phone: _____

Insurance Company: _____

Mailing Address: _____

_____

Group #: _____ I.D. #: _____ Employer: _____

Secondary Insurance: Yes [ ] No [ ]

Name: _____

Insured Address: _____ Phone: _____

Insurance Company: _____

Mailing Address: _____

_____

Group #: _____ I.D. #: _____ Employer: _____

I attest the above information to be true to the best of my acknowledgement. My signature below authorizes Dr. Matthew L. Smith, Psy.D. to release to my insurance company the required information to facilitate appropriate payment. I understand that I am personally responsible for the agreed upon fee my treatment/evaluation entails, even if my insurance does not cover this charge. I agree to make a concerted effort to make regular payments on my outstanding balance; recognizing failure to make this effort of other arrangements could result in my billing being turned over to a collection agency. My signature further acknowledges that I am informed of all office policies and procedures. Furthermore, my signature validates my consent to receive treatment from Dr. Matthew L. Smith, Psy.D.

_____ _____

Signature of Client or Responsible Party Date

I authorize that my mental health information may be provided to my Primary Care Physician Yes [ ] No [ ]

_____ _____

Signature of Client or Responsible Party Date