



# Chane Reaction LLC

Counseling Services  
Linking You To Resources For A Better Tomorrow

## Authorization to Bill Insurance

**Please print the form and bring it with you to your first therapy appointment or upload it to your therapy portal account.**

Client: \_\_\_\_\_ Guardian's Name (if Minor): \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy No. \_\_\_\_\_

Doctor: \_\_\_\_\_ Clinic: \_\_\_\_\_

Phone: \_\_\_\_\_ Location: \_\_\_\_\_

I, the undersigned, hereby certify and attest that I have sought evaluation, treatment, or medical advice from Chane Reaction, LLC. I, therefore, authorize the medical staff and personnel to release my or my minor child's medical information to the insurance company listed above for the purpose of determining and receiving benefits for medical bills. I understand and acknowledge that the medical staff will submit my claim to the insurance company on my behalf.

I further understand that I will be held responsible for any amount of my medical bills not covered by my insurance policy or claims and that I will be responsible for paying all deductibles, fees, co-payments, and co-insurance payments required. I understand that any portion of my medical bills not covered by insurance will be

billed to me at the address I have provided to this agency. Non-compliance or defaulting on payments may result in denial of service and/or a legal claim against me for non-payment.

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Your Signature

Date