Melissa Morrison, MFT
515 Court St, Ste 2A
Reno, NV 89501
(775) 848-8552

Insured/Responsible Party Information:

Occupation: _____SS#: _____ Date of birth: _____

Employer: _____ Work phone: ( ) _____

Insurance Information:

Insured's Primary Insurance Company: _____

I.D.#: _____

Group #: _____ Policy #: _____

Phone No: _____

Address: _____ City: _____ State: _____

Zip: _____

Office Billing and Insurance Policy:

1. I authorize use of this form on all my insurance submissions.
2. I authorize the release of information to my insurance company(s).
3. I understand that I am responsible for the full amount of my bill for services provided if my insurance company does not pay.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of an original.

It is your responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balances not paid by your insurance company the day and time of service provided.

- There will be a $50.00 service charge on all returned checks.
- Pursuant to the collection policy outlined in the Confidentiality Agreement, if your account goes to collections, there will be a 40% collection fee added to your balance.

Signature: _____ Date: _____

Name (Print): _____