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Name _____ Today's Date _____

Address _____

City _____ Home Phone _____

State _____ Zip Code _____ Work Phone _____

Insurance Information

Primary Insurance Company _____

Insurance Billing Address _____

City _____ State _____ Zip Code _____

Insurance Phone _____

Policy Number _____ Group Number _____

Name of Insured (Policy Holder) _____ Relationship to Client _____

Social Security Number (Insured) _____

Employer of Insured _____

Date of Birth of Insured _____

Social Security Number of Client _____

Date of Birth of Client _____

I hereby authorize Todd Ransford, Ph.D. to furnish the above-listed insurance company with information necessary to bill for services. I understand that this information typically includes my name and other identifying information, the dates of service, and a diagnosis code. In the event that the insurance company requests additional information, such as chart notes or treatment plans, I understand that these requests will be discussed with me and additional authorization sought before any treatment-related documents are submitted. By signing below, I also authorize the above-listed insurance company to remit and assign payments directly to Dr. Ransford for services rendered.

Signature _____ Date _____