

INSURANCE SUBMISSION AUTHORIZATION FORM

NAME OF PATIENT (S): _____

BIRTHDATE (S): _____

IF YOU WOULD LIKE TO USE YOUR INSURANCE FOR REIMBURSEMENT, PLEASE PROVIDE THE FOLLOWING:

1. **PHOTO IDENTIFICATION**
2. **COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD. PLEASE EMAIL COPIES TO INFO@THECLINICCA.ORG OR FAX TO (415) 484-7083 OR TEXT TO 415-840-0844.**
3. **SIGN AND DATE THE AUTHORIZATION BELOW:**

THIS DOCUMENT AUTHORIZES THE STAFF OF THE CLINIC TO AUTOMATICALLY SUBMIT ELECTRONIC CLAIMS TO THE PATIENT'S INSURANCE COMPANY FOR CHARGES ASSOCIATED WITH THE TREATMENT OF THE PATIENT NAMED ABOVE. THE UNDERSIGNED ACKNOWLEDGES THAT THE CLINIC IS AN OUT-OF-NETWORK PROVIDER AND IS SUBMITTING CLAIMS AS A COURTESY SERVICE. THE UNDERSIGNED TAKES FULL RESPONSIBILITY FOR FOLLOWING-UP WITH INSURANCE COMPANY REGARDING PAYMENT. PAYMENT WILL BE SENT DIRECTLY TO THE INSURED.

I UNDERSTAND THAT BILLED SERVICES WILL BE SUBJECT TO THE PARAMETERS AGREED UPON BETWEEN MYSELF AND MY TREATING CLINICIAN AND OUTLINED IN THE "POLICIES AND PROCEDURES AGREEMENT." I HAVE RECEIVED A COPY OF THIS AGREEMENT AND UNDERSTAND THESE POLICIES.

SIGNATURE OF INSURED: _____

SIGNATURE OF SECONDARY INSURED: _____

DATE: _____

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