



OT & Me, LLC

Harrisburg, PA

717.364.4360

OTandMePA@gmail.com

### Authorization to Bill Insurance

Client: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Guardian (if Minor): \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy No.: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber date of birth: \_\_\_\_\_

I, the undersigned, hereby certify and attest that I have sought evaluation, treatment, or medical advice from OT & Me, 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 at the time of service. I understand that any portion of my medical bills not covered by insurance will be billed to me at the address I have provided above. Non-compliance or defaulting on payments may result in denial of service and/or a legal claim against me for non-payment.

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Responsible Party Printed Name: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_