Insurance Authorization

I HEREBY AUTHORIZE payment of any insurance benefits covering my care and treatment to be made directly to Julie Hanson, LCSW. I understand, as signee, I am financially responsible to Julie Hanson, LCSW for ***all charges that are not covered by my insurance company.*** I also give Julie Hanson, LCSW permission to release any of my health information obtained during examinations or treatment that may be necessary to support any insurance claims. Further, by signing this form, I acknowledge that Julie Hanson, LCSW is not responsible for securing authorization or coverage by my insurance carrier for my treatment and services, and I understand that Julie Hanson, LCSW cannot be held liable for any limitations of coverage or authorization by my insurance policy.

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Client Signature Date