Elizabeth Elliott, MA LMFT, CMHS
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elliottcounseling.com
(425)322- 9515

Client name: _____ Birthday: _____

Name of Insured Person: _____ Birthday: _____

Address of Insured Person: _____

Phone Number of Insured Person: _____

Client Relationship to Insured: _____

Insurance Company: _____ Plan Name: _____

ID Number on Card: _____ Group Number: _____

Insured Person's Employer: _____

Deductible: _____ Has Deductible Been Met this Year: _____

Number of Sessions Allowed Per Year: _____

Fee without Insurance: $150

Co-Pay Due at Each Session: _____

Late Cancellation/ No Show Fee: $150

- I understand that my portion of the fee (co-pay/co-insurance) is due at time of service.
- I understand that a no-show fee will be charged for appointments cancelled without 24 hours notice. Because insurance does not pay for missed sessions, I will be responsible for the full fee, not just the co-pay.
- I understand that I am responsible for paying my deductible and any amounts not covered by insurance. If I have secondary insurance, I understand that I will be responsible for submitting claims against that insurance, and that I will be responsible for any amount not covered by my primary insurance.
- I understand that if, for any reasons, my insurance company does not pay my fee, I am responsible for the entire amount.
- I authorize the release of information needed to verify and process insurance claims to Elizabeth Elliott, MA, LMFT.

Client or parent signature: _____

Date: _____