



Billing Registration Form

Client Name: _____ Date of Birth: _____ Gender: M / F

Billing Address: _____ Marital Status: S M W D

Client E-mail Address: _____

Do you want Gold Counseling Services, P.C. to submit claims for services provided to your insurance carrier?

(If yes, we will need to obtain a copy of your insurance card (front and back) for our records). YES NO

Name of Subscriber: _____ Subscriber Date of Birth: _____

If you do not want claims submitted to insurance, do you want to receive an invoice for your records?

YES NO

If yes, please initial here to give permission for Gold Counseling Services to email you invoices: _____

Email address for invoices and other billing correspondence (if different than above):

Please read the following carefully and sign below:

I give permission to Gold Counseling Services, P.C. and billing staff to send required information to my insurance company for billing purposes. I understand that:

- a) I am placing my signature on file.
- b) Gold Counseling Services, P.C. will submit claims and provide necessary information for processing, but cannot guarantee whether insurance will accept the claim out of network. In the event claims are not accepted by my insurance, I understand I can request invoices to submit independently and am responsible for contesting claims.
- c) I am responsible for any unpaid balance.
- d) I understand there may be a fee if I fail to give 24 hours' notice for cancellation of my appointment. I understand that my insurance does not cover the cost of missed sessions.

Signed: _____ Date: _____