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Insurance Authorization

The following is required to file health insurance forms for client reimbursement.

- I authorize the use of this form on all my insurance submissions.
- I authorize the release of information to all my insurance companies.
- I understand that I am responsible for my bill, not my insurance company.
- I authorize my therapist to act as my agent in helping me obtain payment from my insurance company.
- I permit a copy of this authorization to be used in place of the original.
- I authorize payment to be made directly to the provider.

Signature on File

Name _____

Please Print

Signature _____ Date _____

Employer Information

(We do not release information to employers, only insurance companies. This information is needed for processing insurance claims only)

Employer Name Address

Human Resources Direct Phone Number Contact Name

Insurance Company Name Address

Insurance Company Phone Number Employee ID #

Name of Insured Effective Date

Insurance Policy # Insurance Group #