INSURANCE BILLING AUTHORIZATION FORM

This form authorizes HOLISTIQ HEALTH LLC to use or disclose your patient health information to bill Medicare, Medicaid, or your private insurance company for evaluation and treatment of your medical/psychiatric conditions.

I request that payment of authorized Medicare, Medicaid, and/or other insurance benefits be made on my behalf to HOLISTIQ HEALTH LLC for services provided me by HOLISTIQ HEALTH LLC, its agents, and employees. I authorize any holder of medical information about me to release to HOLISTIQ HEALTH LLC, Medicare, Medicaid, and/or any other insurance company including its agents and employees, any information or documentation needed to determine these benefits or the benefits payable for related services.

I understand that by signing this form, I request that payment be made to HOLISTIQ HEALTH LLC and authorize release of my medical information necessary to secure payment for the claim. If I have supplemental health insurance coverage, my signature authorizes releasing the medical information to the supplemental insurance company, its agents, and employees. This signature authorization shall remain in effect until revoked by me in writing.

I understand that HOLISTIQ HEALTH LLC is HIPPA compliant, and I have the right to request a copy of HOLISTIQ HEALTH LLC's Privacy Notice and to review it before signing this authorization form. A photocopy of this authorization is to be considered as valid as an original.

_____	_____	_____
PATIENT FULL NAME	DATE	SIGNATURE

BILLING YOUR INSURANCE DOES NOT GUARANTEE PAYMENT. THE AMOUNT PAID BY INSURANCE CANNOT BE GUARANTEED. YOU ARE RESPONSIBLE FOR THE PAYMENT OF YOUR BALANCE.