Rosalino Counseling Services
383 West Fountain Street
Suite 106 and 108
Providence, RI 02903

Consent To Bill Insurance and Receipt of Privacy Policy Name of

Patient: ______________________________________ Date of Birth: ______________ I understand my insurance company will be billed on my behalf and I am responsible for all fees, deductibles, co-payments, and any unpaid portion of my bill. Payment in full is due at time of service unless other arrangements have been made.

Note: Bring your medical insurance cards to your appointment.

If no insurance card is available, please supply the name of the insurance company and ID number in the space below. Ins. Company: ____________________________
ID#__________________________________ Policy Holder's Name: _______________
Policy Holder's Date of Birth: _____________

Consent to Bill Insurance, Authorization, and Release:

- I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such care to third party payers and/or other health practitioners.
- I authorize and request my insurance company to pay directly to the mental health practitioner insurance benefits otherwise payable to me.
- I understand that my insurance carrier may pay less than the actual bill for services.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____ __________________