Eric Groh, LPC

Payment Authorization Information:

It is the policy of this office that payments are made at the time of your visit. Payment can be made by either cash, money order, check.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account. I certify that the demographic information provided to Eric is true and accurate to the best of my knowledge. I will notify the office of any changes in my insurance coverage status or any of the above information immediately. I understand that many insurance panels have timely filing limits and if I do not provide my insurance to therapist, Eric Groh in a timely manner, this can result in claim denials and I will be financially responsible.

I hereby authorize Eric Groh & Total Billing Management Services Inc to bill my insurance company directly for their services. I also authorize assignment of benefits to be sent directly to the physician. I understand that I am financially responsible to Eric Groh, LPC for charges not covered by my insurance company. A photo static copy of other reproduction of this authorization will be valid as the original.

Therapist, Eric Groh will file claims with the insurance company that is provided to our office and we will follow-up on claim issues. Please note that we are not responsible for the decisions made by your insurance company and limitations of your insurance plan.

I have read and understand the information provided above:

Signature: ____

Name: ________________________________ Date: ______________