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### Therapist-Patient Insurance Reimbursement Authorization

You should be aware that your contract with your health insurance company requires that I provide it with information relevant to the services I provide to you.

I am required to provide a clinical diagnosis.

Sometimes I am required to provide additional clinical information such as treatment plans, or copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested.

All clinical information and mental health diagnosis will become part of the insurance company files and will probably be stored in a computer.

Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands.

In some cases, they may share your information with a National Medical Information Databank, or MIB. Should your clinical information become a part of the MIB, any further distribution or actions based on such information is no longer under my control.

It is important to remember that you have the right to pay for my services yourself to avoid the problems described above (unless prohibited by your insurance contract).

In choosing to use your mental health benefits:

You will provide me with a written description of your mental health insurance benefits that you have pre-verified and if necessary pre-authorized with your insurance company. This is the purpose of you providing a copy of the front and back of your insurance card at your initial assessment. Please be aware that this will not be a guarantee of benefits and that final determination of eligibility (and sometimes actual amount paid) will not be made until your insurance company processes any claims I submit. I will fill out the necessary forms and provide you with what assistance I can in helping you receive the benefits to which you are eligible; however, you (not your insurance company) are responsible for full payment of my fees.

By signing this authorization, you agree that I can and will provide requested information to your insurance carrier.

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Sign Name

Print Name

Date \_\_\_\_\_

Relationship to Patient/Client \_\_\_\_\_