Office of Robert Oberlander, L.M.H.C

SECOND PARTY BILLING (GUARANTOR) CONSENT FORM

Patient Name (please print)_____

Person Responsible for the account (please print)_____

Phone Number_____

Relationship to the Patient_____

For the Insured Patient*

I agree to have bills and statements sent to the following address:

_____

In the event that insurance does not cover any or all of these services, I will be responsible for payment of the balance due.

I understand that insurance will not pay for no-shows or late cancellations, and I therefore agree to pay for these.

For Private Pay Patients: I understand that the office policy is pay as you go.

Patient Signature Date

_____

Additional Payor (Guarantor) Signature Date.

*For insured patients, please send a copy of your insurance card.