MENTAL HEALTH INTAKE INFORMATION
FOLLMAN AGENCY, 910 S. ANACORTES STREET, BURLINGTON, WA 98233

PLEASE PRINT

<table>
<tr><td colspan="4">Name</td><td>Date</td></tr>
<tr><td colspan="4">Street Address</td><td>Suite/Apt #</td></tr>
<tr><td colspan="2">City</td><td colspan="2">State</td><td>Zip Code</td></tr>
<tr><td>Phone</td><td colspan="2">Email address</td><td>Age</td><td>Date of birth (m/d/y)</td></tr>
<tr><td>Employer:</td><td colspan="3">Employer's Phone Number:</td><td>Occupation:</td></tr>
<tr><td colspan="4">Name of person with whom you live</td><td>Relationship</td></tr>
<tr><td colspan="3">Name of person to call in an emergency</td><td>Phone</td><td>Relationship</td></tr>
<tr><td colspan="4">Street Address</td><td>Suite/Apt #</td></tr>
<tr><td colspan="3">City</td><td>State</td><td>Zip Code</td></tr>
<tr><td colspan="5">Name of person completing this form (if not client)</td></tr>
<tr><td colspan="5">Name of referring or responsible physician/clinician</td></tr>
<tr><td colspan="4">Street Address</td><td>Suite/Apt #</td></tr>
<tr><td colspan="3">City</td><td>State</td><td>Zip Code</td></tr>
<tr><td colspan="5">Phone</td></tr>
</table>

Do you have a Primary Care Provider and/or Mental Health Provider: **Yes** ☐ or **No** ☐

If yes whom____

Would you like the Follman Agency to communicate with your Primary Care Provider and/or Mental Health Provider? **Yes** ☐ or **No** ☐ (If yes, please fill out a release of information for the provider.)

LEGAL			
Current Legal Charge:			
Court:		Case #	
BAC:	Offense:	Date of Offense:	
Probation Officer:		Contact:	
Outstanding Warrants: ☐Yes ☐No If yes, what and when:			
Past Convictions: ☐Yes ☐No			

Charge	**Date of Charge**	**Court**	**Final Outcome**

Name of Attorney:	**Attorney's Contact:**
Attorney's Address:	

BILLING INFORMATION		
Program Costs:	Payment Plan:	Insurance Company:
Insurance Company Address:	Phone #:	Member #:
Deductible:	Portion Used:	Co-Pay or Percentage Paid:

***Please attach a copy of insurance card here:**

FOLLMAN AGENCY
910 S. Anacortes Street
Burlington, WA 98233
(360) 755-1125 • (360) 757-1125

PATIENT RIGHTS

You have the right to:

- Be admitted to treatment without regard to race, color, creed, national origin, religion, sex, sexual orientation, age, or disability, except for bona fide program criteria.
- Be reasonably accommodated in the event of sensory or physical disability, limited to communicate, limited English proficiency, and cultural differences.
- Be treated in a manner sensitive to individual needs and which promotes dignity and self-respect.
- Be protected from invasion of privacy except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises.
- Have all clinical and personal information treated in accord with state and federal confidentiality regulations.
- Have the opportunity to review the patient's own treatment records in the presence of the agency 's administrator or designee.
- Have the opportunity to have clinical contact with a same gender counselor, if requested and determined appropriate by the supervisor, either at the agency or by referral.
- Be fully informed regarding fees charged, including fees for copying records to verify treatment and methods of payment available.
- Be provided reasonable opportunity to practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. You have the right to refuse participation in any religious practice.
- Be allowed necessary communication.
  - Between a minor and custodial parent or legal guardian;
  - With an attorney; and
  - In an emergency situation.
- Be protected from abuse by staff at all times, or from other patients who are on agency premises, including:
  - Sexual abuse or harassment;
  - Sexual or financial exploitation;
  - Racism or racial harassment; and
  - Physical abuse or punishment.
- Be fully informed and receive a copy of counselor disclosure requirements described under RCW 18.19.060.
- Receive a copy of patient grievance procedures upon request.
- In the event of an agency's closure or treatment service cancellation, you shall be:
  - Given 30 days notice;
  - Assisted with relocation;
  - Given refunds to which you are entitled; and
  - Advised how to access records to which you are entitled.
- This agency shall obtain your consent for the release of information to another person or entity. This consent for the release of information shall include:
  - Name of the consenting patient;
  - Name of the designation of the provider authorized to make the disclosure;
  - Name of the person or organization to whom the information is to be released;
  - Nature of the information to be released, as limited as possible;
  - Purpose of the disclosure, as specific as possible;
  - Specification of the date or event on which consent expires;
  - Statement that the consent can be revoked at any time, except to the extent that action has been taken in reliance on it;
  - Signature of the patient or parent, guardian, or authorized representative, when required, and the date; and
  - A statement prohibiting further disclosure unless expressly permitted by the written consent of the person to whom it pertains.
- This agency shall notify you that outside persons or organizations which provide services to the agency are required by written agreement to protect your confidentiality.
- If an ADATSA recipient, you have these additional rights to:
  - Report back to the department's community service office in case of a disciplinary discharge from the program; and
  - Request a fair hearing to challenge any departmental action which affects your eligibility for ADATSA treatment or shelter assistance.

Signature: ______________________________

CLIENT DISCLOSURE INFORMATION

The Following information is being released to you in compliance with the requirements of WAC 308-190-040: WAC 308-190-040: *"Counselors practicing counseling for a fee must be registered or certified with the Department of Health for the protection of the public health and safety. Registration of an individual with the department does not include a recognition of any practice standards, nor necessarily implies the effectiveness of any treatment."*

The Follman Agency is certified to offer behavioral health treatment by the Washington State Health Department.

The type of treatment that you will receive at this facility mental health treatment. It includes, but is not limited to, individual counseling, group counseling, family counseling, aftercare/discharge planning, and educational services.

All counseling staff of this agency is required to be registered with the Department of Health. A record of each counselor's registration certificate and their registration number are kept in their permanent file in our business office.

All counselors are also required to meet the minimum academic, training, and experience requirements of a qualified counselor as defined by WAC 388-60. In addition, qualified counselors are required to obtain continuing education to maintain their qualified counselor status. This agency is required to keep these records in each counselor's personnel file, which are inspected regularly by Department of Behavior Health Recovery.

You have the right to the counselor registration number and to inspect the academic, training, and experience records of any counselor that you receive treatment from. You may arrange to inspect the above information by writing and calling the office listed below.

Follman Agency
910 South Anacortes Street, Burlington, WA 98233
(360) 755-1125

I have signed consent to treatment and have been advised to the fee schedule.

I have read and understand the above information.

______________________________ ________________
Client Signature Date

______________________________ ________________
Authorized Program Representative Date

Mental Health Treatment Contract

Name:______________________________________ **Date:**__________________________

I agree to participant in my recommended treatment program. In addition to my attendance, I understand and agree to the following conditions. (Please initial each item which applies to you)

________Completing all court ordered requirements mandated by law is my responsibility. I agree to contact The Follman Agency in the event I can not keep my commitment and make special arrangements to make up missed treatment.

________I understand that The Follman Agency by law, must report to my probation officer following conditions:

- Compliance and progress in treatment
- Lack of significant progress in treatment
- If needed, a revised treatment plan

________I understand that The Follman Agency has the authority to alter or change a diagnosis or treatment recommendations made by any evaluating agency and that treatment itself is an ongoing evaluation process.

________I understand that The Follman Agency holds the philosophy that meeting my financial obligations and responsibilities are a measure of my progress in treatment. Failure to keep financial obligations is not showing significant progress in treatment and could result in termination unless special arrangements are made with the financial department and upheld.

________In the event of a medical emergency, and my doctor is not available , I may be given emergency medical treatment by qualified medical personnel or hospital when deemed immediately necessary or advisable by a physician to safeguard my health.

Physician's Name (IF NEEDED)____

Office:________________________________Phone: ______________________________

The concerned court require you to do at least a minimum prescribed treatment program. This program mist be completed as required by law to allow us to sign Department of Licensing forms which require your counselor's signature. This includes progress reporting on all clients and adult probation and parole.

Client Signature:__________________________________Date:______________________

Counselor Signature:______________________________Date:______________________

MENTAL HEALTH PROGRAM RULES

1. You must call and cancel appointments you cannot keep within 24 hours, if possible. Missed appointments are billed at $40.00, which is not covered by insurance.
2. All Persons enrolled in groups or individual sessions at this agency are expected to be coherent when presenting for treatment.
3. Do not come to group or counseling if you have an infectious disease.
4. No alcohol, other drugs or weapons, including knives, are allowed in any facility of this agency.
5. You must meet your financial obligations according to the arrangements you set up. Any account past due 30 days will result in suspended service. **Payments are due before/ on the 20th of each month.**
6. The Follman Agency is not responsible for lost or stolen articles.
7. Abusive language or behavior that threatens human dignity or physically harms another client or staff member is grounds for dismissal from treatment.
8. You must respect the confidentiality of other clients. Who you see here and what you hear must not be taken outside of this agency.
9. You must wear appropriate attire to any agency function. Shoes and shirts are mandatory. If you arrive dressed indecently, you will be asked to leave.
10. It is your responsibility and obligation to see that the above conditions are met.

Client Signature: ______________________________

Date: ______________________________

Follman Agency

State Certified: Alcohol/Drug Recovery Programs • Anger/Domestic Violence Programs
Individual • Adolescent Counseling • Family Counseling

CONFIDENTIALITY OF
MENTAL HEALTH TREATMENT
PATIENT RECORDS

The confidentiality of anger management treatment participant's records maintained by this program is protected by Federal laws and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as Mental Health treatment participant unless:

Please initial below

_____The patient consents in writing; OR

_____The disclosure is allowed by a court order; OR

_____The disclosure is made to medical personnel in a medical emergency; OR

_____The disclosure is made to qualified personnel for research, audit, or program evaluation; OR

_____The patient commits or threatens to commit a crime either at the program or against any person who works for the program; OR

_____The patient talks about hurting oneself, hurting someone else, child abuse, elderly abuse, or pet abuse.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

See 42 U.S.C. §§ 290dd-3, 290ee-3 for Federal laws and 42 C.F.R. Part 2 for Federal regulations.

_________________________ _________________ _________________________

Client's Signature Date Counselor Signature

910 South Anacortes Street, Burlington, Washington 98233
(360) 755-1125 • FAX (360) 757 – 1125
www.follmanagency.com

Follman Agency

State Certified: Alcohol/Drug Recovery Programs ● Anger/Domestic Violence Programs
Individual ● Couples/Marriage ● Family Counseling ●Problem Gambling

DISCLOSURE STATEMENT

JAMES H. FOLLMAN, PhD, LMHC, & CDP

Licensed Mental Health Counselor
Chemical Dependency Professional
State Certified Problem Gambling Counselor

Washington State law requires that mental health counselors provide new clients with a disclosure statement informing them of their rights and specific information regarding the counselor and therapy.

STATE CERTIFICATION

Counselors practicing counseling for a fee must be registered or certified with the department of health for the protection of the public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment. I have the following licenses:

Licensed Mental Health Counselor (#LH00008388)
Chemical Dependency Professional (#CP00001856)
State Certified Problem Gambling Counselor (11-01)

PROFESSIONAL BACKGROUND

EDUCATION

Doctorate Degree in Counseling Psychology, Walden University, Minneapolis, MN
Master of Education, Guidance and Counseling, City University, Bellevue, WA (1993)
Bachelor degrees from Western Washington University (1981) and Eastern Washington University (1989)

Professional Experience

1993 – Present: Follman Agency – Mental Health & Chemical Dependency

THERAPEUTIC APPROACH

Each person's therapy is individually determined according to his or her treatment goals. My clinical orientation emphasizes the importance of using an integrative approach that takes into account the whole person (bio/psycho/social) within the context of their culture and relationships. I utilize cognitive/behavioral strategies for implementing change and clinical hypnosis when appropriate.

The length of therapy varies according to the nature of your concerns. It usually takes a few sessions to clarify the focus of treatment and develop a treatment approach that will best fit with your needs and goals.

CLIENT'S RIGHTS

You have the right to choose a therapist who best suits your needs and goals. You are encouraged to express any questions or complaints about your therapy and you have the right to a referral to another therapist if that need should arise.

The purpose of the Counseling Credentialing Act and the laws regulating counselors is (1) to provide protection for public health and safety and (2) to empower the citizens of the state of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct.

Client confidentiality is assured except under the circumstances covered by state and federal regulations (RCW 18.19.180). The main exceptions include consultations with other clinicians and disclosures that indicate you (1) are about to commit a crime, (2) are involved in child or dependent adult abuse, (3) are a danger to yourself or others, or (4) are unable to meet your own basic needs in taking care of yourself.

For more information or complaints, write to:

Department of Health, Health Professions Quality Assurance
PO Box 47869
Olympia, WA 98504-7669
OR you may call:
(360) 236-4700

PRACTICE STANDARDS

My fee is $125.00 per individual session. A session is 50 minutes. Payment is expected at the time of the appointment unless you have insurance coverage. In that case, please plan to make your co-pay at time of the appointment. In either case, you agree to be financially responsible for all charges. Keeping regular appointments is essential to effective therapy. If you need to cancel an appointment, please call within 24 hours prior to the appointment to avoid a cancellation charge ($40). For emergencies, call 911.

ACKNOWLEDGEMENT OF DISCLOSURE

Your signature below indicates that you have received this disclosure statement and that you have read, understood and agreed to the terms provided.

______________________________ ____________
Client Signature Date

I am satisfied that said person understands and agree to the terms set forth in this disclosure statement.

______________________________ ____________
Jim H. Follman Date

PATIENT DISCLOSURE INFORMATION

WAC 246-810-030 Requires counselors to inform patients of the counselor disclosure law

The purpose of the law regulating counselors is:
a. To provide protection for public health and safety; and
b. To empower the client/patient by providing a complaint process against counselors who commit acts of unprofessional conduct.
Patients/clients have the right to choose counselors who best suit their needs and purposes.
The extent of confidentiality provided by RCW 18.19.180(1) through (6). Note: Federal confidentiality regulations supersede every item in RCW 18.19, so following the federal regulations for informing the client/patient of the federal confidentiality regulations satisfies this requirement.
Patients are to be provided a list of copy of the act of unprofessional conduct in RCW 18.130.180 and the following address and telephone number:

Department of Health
Health professions Quality Assurance Division
PO Box 47869
Olympia, WA 98504-7869
(360) 236-4903

UNPROFESSIONAL CONDUCT

Counselors are subject to discipline by the Department of Health. Cause for disciplinary action for unprofessional conduct is found in RCW 18.130.180 and includes the following:

The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW.
Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;
All advertising which is false, fraudulent, or misleading;
Incompetence, negligence, or malpractice, which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;
Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction.
The possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substance for oneself.
Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice.
Failure to cooperate with the disciplining authority by:
Not furnishing any papers or documents
Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority
Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceeding; or
Not providing reasonable and timely access for authorized representatives of the disciplining authority seeking to perform practice reviews at facilities utilized by the license holder
Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority
Hiding or abetting an unlicensed person to practice when a license is required
Violations of rules established by any health agency
Practice beyond the scope of practice as defined by law or rule
Misrepresentation or fraud in any aspect of the conduct of the business or profession
Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk
Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health
Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service
Conviction of any gross misdemeanor or felony relating to the practice of the person's profession
The procuring, or aiding or abetting in procuring, a criminal abortion
The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means, or procedure which the licensee refuses to divulge upon demand of the disciplining authority
The willful betrayal of a practitioner-patient privilege as recognized by law
Violation of chapter 19.68 RCW
Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding
Current misuse of alcohol, controlled substances or Legend drugs
Abuse of a client or patient or sexual contact with a client or patient
Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or health-related products or series intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards.

FOLLMAN AGENCY
INTAKE FOR MENTAL HEALTH

PHOTO

You have my permission to photograph me for the purpose of staff recognition only. I understand that this is confidential and for use within the FOLLMAN AGENCY only.

__________________________________ ____________________

Client Signature Date

OPEN DOOR POLICY

The insurance provider for Follman Agency requires each counselor to leave his or her office door slightly open during individual sessions, unless otherwise permitted by the client. Please select one of the following:

☐ I prefer the door to be closed during individual sessions.

☐ I prefer the door to remain slightly open during my sessions.

Client Signature Date

APPOINTMENT REMINDER

Please check which you prefer:

☐ It is OK to call and leave an appointment reminder on my phone, if you cannot reach me in person.

☐ Please do **not** call and leave any messages on my phone.

Client Signature Date

ZOOM & EMAIL

You have my permission to email me for all treatment related purposes, including Zoom links for treatment or appointments. I understand that this is confidential and for use within the FOLLMAN AGENCY only.

Client Signature Date

RECORD OF CONSENT TO RECEIVE SERVICES

I herby affirm that I have voluntarily consented to receive services at the **Follman Agency**, and hereby consent to participate in the Mental Health Treatment, which is provided.

Signed: ______________________________ ____________

Client Signature Date

______________________________ ____________

Parent or Guardian Date

______________________________ ____________

Witness to above Signatures Date

The Follman Agency Financial Policy

Thank you for choosing the Follman Agency as your treatment provider. We are committed to your treatment being successful. Please understand your bill is considered a part of compliance with your recommended treatment program.

All patients must complete our information and insurance form before attending group.

Payments are due on/before the 20th of each month. If payment is not received by the 20th, your treatment will be suspended and we request you to not attend group/session until payment is received. Your account will be charged a $10.00 fee for the Suspension Letter. Drug Screen charges will be due at time of service. We accept MasterCard, Visa, Discover and American Express. Accounts more than 90 days past due will be forwarded to SB&C for collections and your account will be charged $20.00 for the collection letter.

Regarding Insurance
The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and a copy of a recent insurance card. Your insurance is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits we require that you be pre-approved on our extended payment plan. Please be aware that some, and perhaps all, of the services provided may be non-covered services.

Regarding Insurance Plans where we are a participating provider. All deductibles are due prior to treatment. All copays are to be paid according to your payment plan. In the event your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients and Minor Patients.
Adult patients are responsible for full payment at time of service. **Minor Patients**: The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card or payment by cash or check at the time of service has been verified.

Missed Appointments/No Show
Unless canceled at least 24 hours in advance, our policy is to charge $40.00 for missed appointments. Please help us serve you better by keeping your scheduled appointments. Follman Agency reserves the right to not treat a patient after the patient has missed three scheduled appointments. For new patients who miss their evaluation or intake appointment without 24-hour cancelation notice will be required to prepay the missed appointment fee before scheduling any future appointment.

Interest
We reserve the right to charge interest in the amount of 5% as provided by state law.

Non-Compliance
In the event you leave treatment without paying and wish to re-start, you are subject to a $50.00 re-start fee. Please note that failure to pay will result in non-compliance of your treatment program.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X____ Date ____________________
Signature of Patient (Please Print Patient's Name Clearly Below This Line)

____

X____ Date ____________________
Signature of Parent/Guardian

FOLLMAN AGENCY FINANCIAL AGREEMENT

DATE: ______________ **NAME:** ____ **DOB:** __________

I hereby agree to immediately advise the FOLLMAN AGENCY of any changes in:

1. Change of address/phone number
2. Insurance Coverage
3. Employment Status

I hereby agree to pay all fees for services currently or previously rendered by the Follman Agency. I understand the full monthly payment must be made on my account by the 20th of every month or my account will be subject to a $10.00 late payment fee. Also, I am aware that I will be suspended from treatment immediately if payment is not made. I will contact the Follman Agency to reestablish a payment schedule or services may be discontinued until payments are current. In the event of default of payment, I will be held liable for the unpaid balance, including any attorney or collection fees permitted by law. I understand accounts 90 days past due will be sent to collections (SB&C, LLC).

I understand my records are protected under the Federal and State Confidentiality Regulations and cannot be *disclosed without my written consent unless otherwise provided within the Regulations. I also understand I may* revoke this consent at any time except to the extent action has been taken in reliance on my account (i.e., probations, courts, etc.) and in any event this consent will expire when my account is paid in full.

RELEASE OF INFORMATION: I authorize the Follman Agency and/or the Insurance Company to release any information required to process claims.

RELEASE OF BENEFITS: I hereby authorize my Insurance Benefits to be paid directly to the Follman Agency.

TREATMENT PROGRAM: ____

PROGRAM CHARGES:

Down Payment	Monthly Payment	Program Cost
$350.00 Down Payment		

I agree to pay the Follman Agency in monthly installments of $ __________ per month until the fee of $__________ is paid in full. I agree to make a down payment of $____________, which shall be applied to the end of my payment schedule.

____

Patient Signature Above Line (Please Print Clearly Below)

910 South Anacortes Street, Burlington, Washington 98233
(360) 755-1125 • FAX (360) 757 - 1125
www.follmanagency.com

RELEASE STATEMENT FOR INSURANCE CLIENTS

Dear Subscriber and Client,

In order for us to bill your insurance carrier, for either you or a family member, we need a signed statement from both the client and subscriber.

For the Client:

I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits either to myself or to Follman Agency.

Client Name (please print) ______________________________

Client/Authorized Signature ______________________________ Date ______________

For the Subscriber:

I, the subscriber, authorize payment of medical benefits to Follman Agency for services rendered as specified on the HCFA 1500 form (standard billing form). Additionally, I agree to sign and return any two=party payment issued to Follman Agency and myself within 10 days of receipt.

Subscriber Name (please print) ______________________________

Subscriber/Authorized Signature ______________________________ Date ______________