ANDI BLAYLOCK, LCSW
COUPLES, RELATIONSHIPS,
PREMARITAL, FERTILITY, ADOPTION

Billing Authorization Form

Please complete the following information in order to bill your credit or debit card for therapy fees or insurance co-payments. This form will be kept in a locked file. This information should be updated in the event of any changes.

I authorize Andi Blaylock, LCSW, to use the information below to charge my credit/debit card in the event:

- **I do not attend a scheduled therapy appointment that I have not cancelled at least 24 hours in advance,**
- **I do not pay any balance due left by myself or my insurance company, or**
- **My check is returned for any reason (an additional $30 is assessed for returned checks).**

Card vendor: Visa MasterCard Discover AmEx Card type: Credit Debit

#:_____ Expiration date:_____ Verification/Security Code:_____

Name as printed on card: _____

Billing Address: _____

City: _____ State: _____ ZIP:_____

Phone Number: _____

Check here for self-pay □ OR Complete the following information for insurance billing:

Insurance Carrier: _____

Primary Insured: _____ DOB: _____

Group#: _____ Identification#: _____

My signature gives authorization, to send required information to my insurance company for billing, AND to charge my credit/debit card on an ongoing basis for scheduled appointments.

Signature:_____ Date:_____

COUPLE COUNSELING CHICAGO
WWW.ANDIBLAYLOCK.COM
INFO@ANDIBLAYLOCK.COM

4636 N. RAVENSWOOD AVENUE, SUITE 201
CHICAGO, IL 60640
P: 312-882-4817 F: 740-888-4817