Stefanie L. Rose, MA ▪ Licensed Marriage & Family Therapist ▪ 600 Twelve Oaks Center Drive, #642A Wayzata, MN 55391

Account Information

CONFIDENTIAL

INSURANCE INFORMATION CLIENT'S NAME		**RELATIONSHIP TO POLICY HOLDER** ☐ SELF ☐ SPOUSE ☐ CHILD
NAME policy holder		
ADDRESS policy holder		
BIRTH DATE policy holder	EMPLOYER policy holder	
INSURANCE COMPANY name		
billing address		
PHONE NUMBER Insurance company		
ID NUMBER	GROUP NUMBER	

INSURANCE RELEASE:

I understand that Stefanie Rose, MA, LMFT, may be required to furnish information about me to the insurance company indicated above in order to receive payment for services provided and I authorize her to do so.

SIGNATURE: DATE:

Please complete this section. Your account must be guaranteed with a credit card.

PRE-AUTHORIZED HEALTH CARE FORM FOR CREDIT CARDS

I hereby authorize Stefanie Rose, MA, LMFT, to keep my signature on file and to charge my account for the balances of customary charges for services provided to me and/or my family. I understand that this authorization will remain in force until Stefanie Rose, MA, LMFT, has received written notification from me of its termination, in such time and in such manner as to afford Stefanie Rose, MA, LMFT, a reasonable opportunity to act on it.

CARDHOLDER'S NAME as it appears on the card			
ADDRESS where statement is mailed			
☐ VISA ☐ MASTERCARD	CREDIT CARD NUMBER	EXP. DATE	CVV CODE
SIGNATURE:		DATE:	

GUARANTEE OF ACCOUNT:

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services provided. I certify that the above information is correct to the best of my knowledge and that I will notify you of any changes. Choose one option below.

Initials_____**Bill directly to my credit card.**

Initials_____**Bill me first for the balance. My credit card will be billed if no payment is received within 30 days.**

SIGNATURE: _____ DATE: _____