Nan Fitzgerald, LCSW
780 W. 2000 W. Suite A103 #G
Syracuse, UT 84075
801-888-4990
nan.connectionscounseling@gmail.com

Authorization to bill insurance

I, _____, hereby give my consent for Connections Counseling, LLC/Nan Fitzgerald, LCSW to bill my/my child's insurance carrier for the services rendered to my child/family by the above-mentioned provider. In addition, I agree to pay Connections Counseling, LLC/Nan Fitzgerald, LCSW any deductible or uncovered charge in accordance with my health care plan.

Patient/Parent/Guardian Signature: _____ Date: _____

Authorization to release medical information to insurance carrier

I understand that my express consent is required to release any health care information relating to testing, diagnosis, psychiatric disorders, or drug/alcohol use. I, _____, hereby give my consent for Connections Counseling, LLC/Nan Fitzgerald, LCSW to release medical and other relevant information to our insurance carrier as required my my/our insurance carrier to process medical billings.

Patient/Parent/Guardian Signature: _____ Date: _____