Carolyn Rodenberg, MA, LMFT, CCH
Caring Presence Psychotherapy, PLLC
9500 Roosevelt Way N.E., Suite 210, Seattle, WA 98115
(206) 367-3058 WA State License # LF00000863

Payment Agreement

I may be a preferred or participating provider with your insurance company. However, I cannot guarantee payment for my services by your carrier. *It is your responsibility to verify your insurance benefits including co-pay, co-insurance and deductible before your first appointment.* Your payment is due at the end of each session in cash, or check payable to Caring Presence (an abbreviation for Caring Presence Psychotherapy, PLLC). My Disclosure Statement contains more information on fees, and is included as part of this Agreement. You may call MD Commerce, at 1-800-682-2037 (ext. 135) for billing questions. Please bring your insurance card to your first session.

Please complete: Co-pay_______ Yearly deductible ________Driver's license #____________________________

Primary Insurance Company ____Phone ____________________

Insurance Claims Address

____
Street City State Zip code

Subscriber's name ____ Date of Birth ______________________

Subscriber's address ____
Street City State Zip code

Relationship to you: Self _________ Spouse ________ Partner ________ Parent ________ Dependent _________

ID number as shown on insurance card ___________________________Group Number _____________________

Employer of Insured ____ Phone ____________________

Secondary Insurance Company ____Phone ____________________

Insurance Claims Address ____
Street City State Zip code

Subscriber's name ____ Date of Birth _____________________

Subscriber's adddress____
Street City State Zip code

Relationship to you: Self _________ Spouse _________ Partner ________ Parent ________ Dependent ________

ID number as shown on insurance card ____________________________ Group Number ____________________
Employer of Insured ____ Phone _____________________
Financial Responsibility: I authorize the release of any information necessary to process insurance claims arising from my psychotherapy treatment. I assign any insurance payments to Caring Presence Psychotherapy, PLLC, and *I hereby acknowledge full responsibility for payment, as described above, including reference to the Disclosure Statement.*

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Please SIGN your name here Date *Please PRINT your name here*

Revised 1/11/16