DEL MUNDO
PSYCHOLOGICAL, APC

17621 Irvine Boulevard, Suite 214, Tustin, CA 92780
www.delmundopsych.com

AUTHORIZATION TO BILL INSURANCE FORM

Client's Name:_____ DOB:_____
Address:_____ Phone #:_____

Insurance Information
Insurance Company:_____
Subscriber ID#:_____ Policy/Group #:_____

Primary Insured Name:_____ DOB: _____
Insured's Employer:_____

- By signing below, I understand that the office of Del Mundo Psychological (provider) will bill my insurance company for any psychotherapeutic treatment or services rendered.
- I understand all billing is handled through a third party, A Medical Billing Co., Inc..
- I authorize provider to use and/or disclose certain protected health information (PHI) about me, including but not limited to, my name, date of birth, address, phone number, diagnosis, dates of service, and treatment details to A Medical Billing Co., Inc. and my insurance company for the purpose of properly processing insurance claims for payment.
- I authorize the insurance payment to be directed to provider for services rendered. If payments are received by me, I understand that it is my responsibility to reimburse the provider with the received amount in a timely manner (within 30 days).

I do not have to sign this authorization in order to receive treatment from Del Mundo Psychological. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Del Mundo Psychological at 17621 Irvine Boulevard, Suite 214, Tustin, CA 92780.

_____ _____
Signature of Client or Client's Legal Guardian Date

_____
Relationship to Client