ALMA THERAPY
JANETTE S. CORDERO, LCSW-S
p: 512.522.2067
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CONSENT TO BILL INSURANCE

Name of Insurance Holder | Relationship to Client | Insurance Holder's DOB

Insurance Holder's Address | Insurance Holder's Phone Number

Name of Insurance Company | Provider/Mental Health Services Phone Number (on back of card)

ID Number | Group Number

I consent for ALMA Therapy to bill above insurance for mental health services rendered. I am responsible for ensuring services are covered by current insurance provider; if not covered at time of services, I understand I will be billed at the rate of $135/hour. This includes telehealth sessions.

In addition to this form please provide a digital (scanned, picture) copy of your insurance card.

Client Signature | Date

Printed Name of Client