Lara Fielding, Psy.D., Ed.M.
(CA PSY24351)

AUTHORIZATION TO EXCHANGE/DISCLOSE INFORMATION TO INSURANCE COMPANY

I, _____, give my authorization to Lara Fielding, Psy.D., and her employees to submit claims on my behalf to my insurance carrier _____ for psychological services provided. I also give Dr. Fielding and her employees permission to contact my insurance company to request my benefit information.

I understand that, in order to process a claim or provide benefit information, my insurance carrier will likely request private health information pertaining to my medical history, including but not limited to diagnosis, treatment history, plan, and progress, dates of service, policy number, date of birth, address, and the names of other health care providers providing past or present treatment. I give my permission for Dr. Fielding and her employees to release this information to the insurance company and I understand that once information is released to the insurance company, Dr. Fielding cannot guarantee that the information will remain confidential.

I understand that Dr. Fielding is a "out-of-network" provider for all insurance carriers. If I have a PPO or POS-type of policy, the claim from Dr. Fielding will be processed under my policy's "out-of-network" benefit. I understand that the actual amount paid by the insurance company under my "out-of-network" benefit is solely determined by the insurance company according to the terms of my particular health insurance policy.

I understand that sometimes benefit information provided by the insurance company may be inaccurate and that the actual amount paid on a processed claim may differ significantly from the initial estimate provided by the insurance company. If the insurance company pays less than the initial estimate, I agree to be responsible for the difference. Any exceptions to this policy must be agreed to in writing and signed by both the client and Lara Fielding, Psy.D.

Finally, I understand that Dr. Fielding and her employees may submit claims on my behalf as a courtesy. However, I am solely responsible for following up with my insurance company and making sure that the claims have been received and have been processed properly. If there is any known or unknown problem with a claim, the extent of Dr. Fielding's and her employees' responsibility is to resubmit a revised claim to the insurance company at my request.

This authorization will expire on: ____/_____/____; or one month past the time of termination of therapy.
I have the right to revoke this authorization in writing except to the extent that Dr. Fielding or her employees has acted in reliance upon this authorization. My written revocation must be submitted to Lara Fielding, Psy.D., Ed.M. In consideration of this consent, I hereby release Lara Fielding, Psy.D., Ed.M. and the above named parties from any and all liability arising there from.

Client: _____

Print name Signature Date

1964 Westwood Blvd., Suite 310 • Los Angeles, California 90025
310.963.1773