Dr Cynthia Edwards-Hawver and Associates
411 Davis Street
Clarks Summit, PA 18411
570 575 3765

Authorization and Insurance Release of Information

By signing this document, I am allowing Dr. Cynthia Edwards-Hawver and Associates, LLC to release any medical/psychological information necessary in order to process my insurance claims. Dr. Cynthia Edwards-Hawver and Associates, LLC uses a confidential, HIPPA compliant billing software program (Theranest).

I hereby authorize Dr. Edwards-Hawver and Associates, LLC to apply for benefits on my behalf for covered services rendered by their order. I understand that I will be personally responsible for any amount denied or any remaining amount owed for services partially covered by my third-party payer/insurer.

I permit a copy of this authorization to be used in place of the original. By signing below, I acknowledge I understand that Dr. Edwards-Hawver and Associates, LLC may need to release my diagnosis, dates of service, treatment goals, treatment notes, and other information in order to receive reimbursement through your insurance company. If you do not want this information shared with your insurance company, then you will be required to pay out of pocket for services.

Client's Printed Name _____

Policy Holder's Name _____

Policy Holder's Complete billing address:

Street _____

City _____ State_____ Zip Code _____

Policy Holder's Phone Number _____

Policy Holder's Date of Birth _____

Relationship to Policy Holder _____

Insurance Company Name _____

Insured ID Number (with prefix) _____

Insurance Phone Number _____

Current unpaid Insurance deductible $_____

Copayment or Co-Insurance due on Date of Service $ _____

Client Signature _____ Date _____