Equanimity Partners Inc./Weightless Solutions
RELEASE OF INFORMATION TO INSURANCE COMPANY

Policy holder's full name:

Date of birth:_____Identification #:_____

Client's full name (if different):

Date of birth:_____Identification #:_____

Insurance company name:_____

Policy #:_____ Certification #:
Other Coverage Information Required by Insurance Company:

I understand that I am financially responsible for all charges incurred regardless of whether or not they are covered by my insurance policy.

I understand that it may take in excess of 30 days to receive payment or notification of non-payment by my insurance company.

I authorize the Equanimity Partners Inc. / Weightless Solutions Psychotherapy Clinic to release the information required by my insurance company for the purposes of filing claims for reimbursement to me of my payment for services.

I understand that information that may be requested by my insurance company is typically considered private and confidential.

I have specified the specific information to be released and any limitations on the release of information on the attached **RE/RELEASE OF INFORMATION** form, which has been appropriately signed and dated.

Signature of Client Date

Witness Date