Floyd Covey, D.D.; Th. D.; Ph. D.; C. Carm. of C.T.P.; O.SS.T.
Bishop / Priest / Psychologist / Monk
Counseling from a Christian View
Soul Care and Wisdom Guidance

SIGNATURE ON FILE CARD

_____ I authorize Dr. Covey and his staff to use this form on all of my insurance submissions.

_____ I authorize Dr. Covey and his staff to release information to all of my insurance companies.

_____ I understand that I am responsible for my bill with Dr. Covey.

_____ I authorize Dr. Covey and his staff to act as my agent in helping me to obtain payment from my insurance company/companies.

_____ I authorize the insurance company to make payment directly to Dr. Floyd Covey.

_____ I permit a copy of this authorization to be used in place of the original.

AUTHORIZATION TO RELEASE INFORMATION CONCERNING MY APPOINTMENTS

I authorize Dr. Covey and his staff to release information concerning my appointment times, locations, and dates (NOT counseling discussions) to the following people and/or insurance company.

1. _____
2. _____

AUTHORIZATION TO RELEASE INSURANCE AND BILLING INFORMATION

I authorize Dr. Covey and his staff to release information concerning my insurance and billing account with Dr. Covey to the following people (such as spouse or accountant):

1. _____
2. _____

Name of Patient: _____
Signature of Patient: _____ Date: _____
Name of Guardian (If Patient is a Minor): _____
Relationship of Guardian to Patient: _____
Signature of Guardian: _____ Date: _____

(rev. 2023)