HOLLYBURN
Support Services

Direct Billing Consent Form

CLIENT RECEIVING SERVICE

FIRST NAME	LAST NAME
DATE OF BIRTH *(yyyy.mm.dd)*	COUNSELLOR/PRACTITIONER NAME

If the client above is not the primary policy holder, please complete the following:

POLICY HOLDER INFORMATION

FIRST NAME	LAST NAME
DATE OF BIRTH *(yyyy.mm.dd)*	RELATIONSHIP
INSURANCE PROVIDER	
POLICY/GROUP/PLAN NUMBER	
MEMBER/ID NUMBER	

Consent to Direct Bill Insurance Provider

I, the undersigned, authorize Hollyburn Support Services Ltd. to submit claims on my behalf to my extended health insurance provider **through secure electronic billing platforms** and to release any necessary information required for the processing of claims related to counselling services.

I understand and agree to the following:

- It is my responsibility to verify my coverage details, including eligible providers (e.g. RCC, CCC, or RSW), session limits, and whether a physician's referral is required.
- Hollyburn Support Services Ltd. cannot guarantee reimbursement or payment from my insurer and is not liable for any denied or delayed claims.
- I remain financially responsible for any unpaid balance, including deductibles, co-payments, or amounts not covered by my insurance plan.
- This consent remains valid until I revoke it in writing.
- I may opt to pay upfront and self-submit at any time.

- I understand that personal health information may be stored, transmitted, and processed electronically for the purpose of direct billing in accordance with provincial and federal privacy legislation.

- If submitting electronically, I acknowledge that electronic signatures, typed names, or checked boxes indicating agreement are considered legally binding under the Electronic Transactions Act (BC) and similar applicable laws.

- If I have coverage under more than one insurance plan, I acknowledge that Hollyburn Support Services Ltd. will direct bill **only one insurer per session**. I am responsible for confirming which insurer is to be billed and for any unpaid balance resulting from coordination of benefits, partial reimbursement, or claim denial.

By signing below, I confirm that I am the policy holder or am authorized by the policy holder to provide consent, and that I have read, understand, and agree to the terms above, including consent to direct billing by Hollyburn Support Services Ltd.

SIGNATURE		
NAME (PRINTED)	SIGNATURE	DATE

This form may be completed electronically or in person. Please ensure all required fields are completed and submit the form by emailing it to counselling@hollyburn.ca or by providing it to your counsellor prior to your first session.