

**University of Central Florida Counseling & Psychological Services (CAPS)**

|  |
| --- |
| **Name:** |
| **Date:** |

**4090 Libra Drive**

**Orlando, FL, 32816-3170**

**Ph: (407)823-2811 Fax: (407)823-5415**

**BILLING FORM**

TO: BAYCARE

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Status:

* Full time
* Part time

# This is to verify that the above named student has attended:

* an initial assessment on at (Invoice# )

date time

* a counseling appointment on at (Invoice(s)# )

date time

Provider ID#: 4072353599

# Authorization to Release Confidential Information

I, , hereby authorize the UCF Counseling & Psychological Services (CAPS) to release this form to myself and the above named entity to document services that I have received.

I understand that after this form is released, CAPS cannot guarantee the confidentiality of this document. I understand that I can obtain a copy of this authorization. A copy of this form is as valid as the original. I understand that I have the right to refuse to sign this form and that I may revoke my consent at any time (except to the extent that the information has already been released.) This revocation must be delivered in writing to CAPS staff listed above. This consent will automatically expire one year from the date of client’s signature.

Signature of Client Date

Signature of Parent/Legal Guardian (if applicable) Date