

POLICY HOLDER: PATIENT NAME:

DATE OF BIRTH: \_

# AUTHORIZATON FOR ASSIGNMENT OF BENEFITS

I authorize West Psychological Services PLLC to apply for benefits from my insurance carrier and further authorize payment directly to West Psychological Services PLLC who accepts assignment of the healthcare/medical benefits, for services rendered.

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| **YEAR** | **SIGNATURE OF RESPONSIBLE PARTY** | **DATE OF SIGNATURE** |
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# AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of health/medical information required by my insurance carrier or its designated review agent, in order to determine benefits to which I may be entitled, or to designated agents of West Psychological Services PLLC.

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| **YEAR** | **SIGNATURE OF INDIVIDUAL, PARENT OR GUARDIAN** | **DATE OF SIGNATURE** |
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# MEDICARE PATIENTS ONLY

Beneficiary: ID Number:

I request that payment of authorized Medicare benefits be made on my behalf to West Psychological Services PLLC, for all services furnished to me by West Psychological Services PLLC. I authorize any holder of medical information about me to release to the Health care Financing Administration and its agents any information necessary to determine benefits or benefits payable for related services.

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| **YEAR** | **SIGNATURE OF BENEFICIARY** | **DATE OF SIGNATURE** |
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This entire authorization is valid for all episodes of care rendered by all providers associated with West Psychological Services PLLC. I permit a copy of this authorization and agreement to be used in place of the original.

Authorization for Assignment of Benefits/Release of Information