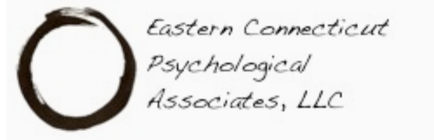

Assignment of Benefits Form

Financial Responsibility

All professional serves rendered are charged to the patient and are due at the time of service, unless other arrangements have been made.

Assignment of Benefits:

I hereby assign all medical/mental health benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment directly to Eastern Connecticut Psychological Associates, LLC or your individual therapist for services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Authorizing to Release Information:

I hereby authorize Eastern Connecticut Psychological Associates, LLC to: (1) release any information necessary to insurance carriers regarding my diagnosis and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested mental health services from Eastern Connecticut Psychological Associates, LLC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

____

Printed name of person signing below

____ ____________________

Patient/ Responsible Party Signature **Date**