Amy E. Brown, MS, CAC, LPC, SAP
780 E. Market St #280 ~ West Chester, PA 19382
T 610 416 0793 ~ F 610 566 3274

Assignment of Insurance Benefits:
I hereby assign all 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 **Amy E. Brown, MS, CAC, LPC** 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 **Amy E. Brown, MS, CAC, LPC** to: (1) release any information necessary to insurance carriers regarding my diagnosis and treatment; (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 **Amy E. Brown, MS, CAC, LPC** 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)

_____ _____
Patient Date

_____
Printed name of person signing below (subscriber if other than patient)

Subscriber _____ Date _____