ASSIGNMENT OF BENEFITS

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SUBSCRIBER'S NAME:		DATE OF BIRTH:
SUBSCRIBER'S SSN:		RELATIONSHIP TO PATIENT:
SUBSCRIBER'S ADDRESS:		
PHONE: HOME	WORK	CELL
PRIMARY INSURANCE COMPANY:		ID#
GROUP#:		PHONE#:
SECONDARY INSURANCE COMPANY:		ID#:
SUBSCRIBER'S NAME/DOB/SSN IF DIFFERENT:		
MEDICAID INFORMATION #:		
IS ANOTHER INSURANCE PAYOR BEFORE YOUR MEDICAID? YES OR NO		
HAVE YOU OBTAINED A CMN? YES OR NO		

I HEREBY INSTRUCT AND DIRECT_____ (INSURANCE COMPANY) TO PAY BY CHECK MADE OUT TO "CONNECTIONS THERAPY CENTER" AND MAILED TO THE ADDRESS BELOW (NOT MINE). IF MY/THIS CURRENT POLICY PROHIBITS DIRECT PAYMENT TO DOCTOR/THERAPIST, I HEREBY ALSO INSTRUCT AND DIRECT YOU TO MAKE OUT THE CHECK TO ME AND MAIL IT TO THE ADDRESS BELOW FOR PAYMENT OF THE PROFESSIONAL OR MEDICAL EXPENSE BENEFITS ALLOWABLE AND OTHERWISE PAYABLE TO ME UNDER THE CURRENT INSURANCE POLICY AS PAYMENT TOWARD THE TOTAL CHARGES FOR THE PROFESSIONAL SERVICES RENDERED.

THIS IS DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. THIS PAYMENT WILL NOT EXCEED MY INDEBTEDNESS TO THE ABOVE-MENTIONED ASSIGNEE, AND I HAVE AGREED TO PAY, IN A CURRENT MANNER, ANY BALANCE OF SAID PROFESSIONAL SERVICE CHARGE OVER AND ABOVE THIS INSURANCE PAYMENT.

PLEASE CHECK EACH BOX AND SIGN AT BOTTOM.

_____ A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL

_____ I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION PERTINENT TO MY CAUSE TO ANY INSURANCE COMPANY, ADJUSTER, OR ATTORNEY INVOLVED IN THIS CASE FOR THE PURPOSES OF PROCESSING CLAIMS AND SECURING PAYMENT OF BENEFITS

_____ I AUTHORIZE THE USE OF THE SIGNATURE ON ALL INSURANCE SUBMISSIONS

_____ I AUTHORIZE CONNECTIONS THERAPY CENTER TO DEPOSIT CHECKS MADE IN MY NAME

_____ I AUTHORIZE CONNECTIONS THERAPY CENTER TO INITIATE A COMPLAINT TO THE INSURANCE COMMISSIONER FOR ANY REASON ON MY BEHALF

_____ I UNDERSTAND THAT I AM FINANCIALLY RESPONSBILE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE

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SIGNATURE OF POLICY HOLDER DATE WITNESS