

ASSIGNMENT OF BENEFITS AND BILLING AUTHORIZATION FORM

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance. You agree to fill out and execute any additional necessary forms that may be required for your insurance carrier. In some cases, the exact insurance benefits cannot be determined until the insurance company receives the claim and the claim is adjudicated.

Client Name _____ Date of Birth _____

Primary Insurance _____

Insurance Policy Holder Name _____

Policy Holder Date of Birth _____

Insurance Policy Holder Address _____

Relationship to client: self spouse parent

Paper Claims Address _____

Electronic Claims Payer ID/EDI# _____ Insurance Provider Phone# _____

Primary Insurance Policy # _____ Group # _____

Pre-certification Required YES NO

Co-Payment Amount _____

Secondary Insurance _____

Insurance Policy Holder Name _____

Policy Holder Date of Birth _____

Insurance Policy Holder Address _____

Relationship to client: self spouse parent

Paper Claims Address _____

Electronic Claims Payer ID/EDI# _____ Insurance Provider Phone# _____

Secondary Insurance Policy # _____ Group # _____

Pre-certification Required YES NO

Co-Payment Amount _____

Within You Counseling, LLC
Festus, Missouri
(636) 465-0760
www.withinyoucounseling.com

Assignment of Benefits

I hereby assign all medical and mental health benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicaid, private insurance, and any other mental health/medical plan, to issue payment check(s) directly to **Within You Counseling, LLC** for therapy services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **Within You Counseling, LLC** to:

1. Release any information necessary to insurance carriers regarding my therapy and sessions. I understand that my therapist may be required to release certain information to the insurance company at their request in order to procure necessary authorizations and/or process claims for payment. This information may include, but is not limited to types of service, dates of service, times of service, diagnosis, treatment plans, progress of therapy and at times, treatment notes and/or summaries. I authorize the release of such information if necessary, understanding the limits of confidentiality regarding the use of my insurance benefits. I also acknowledge receipt of **Within You Counseling, LLC**'s Notice of Privacy Practices.
2. Request payment of insurance benefits be made directly to **Within You Counseling, LLC** for services performed.
3. If necessary, file a formal written complaint, if permitted by law, on my behalf to the state Insurance Commissioner, or other appropriate state agency, if payment for services is not timely received.

I have requested therapy services from **Within You Counseling, 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 all 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.

Client Signature: _____ Date: _____

Printed Name: _____

Legal Guardian Signature: _____ Date: _____

Printed Name: _____

Clinician Signature: _____ Date: _____

Brandi Gillam, Licensed Professional Counselor