

**ASSIGNMENT OF BENEFITS**

I request that payment of authorized insurance benefits to be made on my behalf to the organization listed below for any services provided to me by that organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. By signing this document, I also acknowledge that I have the right to request a copy of the organization’s Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

**Dr. Deb’s Center for Child and Family Development**

BY SIGNING BELOW, I AM AGREEING TO THE AUTHORIZATIONS, CONSENTS, AND RELEASES DESCRIBED IN THIS AGREEMENT. I HAVE READ THIS AGREEMENT AND HAVE BEEN ABLE TO ASK QUESTIONS.

DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PATIENT’S SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT’S PRINTED NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF THE SIGNATURE ABOVE IS NOT THE PATIENT’S, INDICATE BELOW THE RELATIONSHIP OF THE PERSON SIGNING FOR THE PATIENT.

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
(e.g., Parent, Guardian or Authorized Representative)