Insurance Information

(please give your insurance card to your provider so a copy can be made for your file)

Primary Insurance Name:_____

Subscriber's Name:_____DOB:_____
Last first M.I.

Insured's ID#:_____Group#:_____

Relationship to subscriber:_____

Secondary Insurance Name:_____

Subscriber's Name:_____DOB:_____
Last First M.I.

Insured's ID#_____

Relationship to subsriber:_____

Assignment of Benefits

I request that payment of authorized insurance benefits be made on my behalf to my provider at Anodyne LLC for any services provided to me by that provider. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services to the providers, the Health Care Financing Administration, my insurance company, or other medical entity. A copy of this authorization will be sent to the health Care Financing Administration, my insurance company or other entity if requested. The providers will keep the original authorization on file.

Payment for Services Rendered

I acknowledge that I have a responsibility of paying my co-pay or paying my co-insurance at the time of each service. 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 bills as determined by Kittie Rogers, LCSW or my health care insurer if the submitted claims or any part of them are denied or not covered for payment. It is my responsibility to notify my provider of any changes in services. In the event that I am unable to pay in full, I agree to arrange a financial agreement at the time of each service. I am aware that any unpaid balance over 90 days can be referred to a collection agency. I understand by signing this form I am accepting financial responsibility as explained above for all payment of services received.

By signing this document I acknowledge that I have read, understand, and will comply with its contents.

_____ _____
Client/Guardian Signature Date

_____ _____
Witness Date