INSURANCE ASSIGNMENT & RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with:

Name of Primary Insurance Company: _____
and/or Name of Secondary Insurance Company: _____

and assign directly to Freedom Counseling Center, Inc. all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance. Please be advised that we do not accept Medicaid HMO as a secondary insurance.

The above named institution may use my health care information & may disclose such information to the above named Insurance Company(ies) & their agents for the purpose of obtaining payment for services & determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Insurance Company:_____Phone: _____

Insurance Co. Address: _____ Zip: _____

Name of insured: _____ Insured SS#: _____

Insured Birth Date: _____ Insured Employer: _____

Insured Address: _____ Cite/State/Zip: _____

Medicare/Medigap Authorization

Patient's Name: _____Date of Birth: _____

Medicare Number: _____ Patient ID No.: _____

For any services furnished to me by the provider, I request that payment of all authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to:

_____

Name of Doctor, Clinic, Healthcare Provider or Supplier

To the extent permitted by law, I authorize any holder of medical or other information about me to relase to the Center for Medicare Services, my Medigap insurer, and their agents any information needed to determine these benefits for related services.

_____ _____

Please type the name of Patient, Guardian or Personal Representative **Relationship to Patient**

_____ _____

Signature of Patient, Guardian or Personal Representative Date