ASSIGNMENT OF BENEFITS

INSURANCE INFORMATION:
Subscriber: _____ M F SS#: _____ DOB: _____

Employer: _____ Insurance Co. _____

Insurance Phone #: _____ Plan #: _____ Policy #: _____

Other Pertinent Information (i.e. name of case manager, human resource contact, or any other information to assist in processing your claims): _____
_____

FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT:
I certify that the preceding information is true and correct to the best of my knowledge. I will notify **THE T.E.A.M. APPROACH** immediately of any changes in my health insurance coverage or any of the above information.

I have requested therapy services from **THE T.E.A.M. APPROACH** on behalf of myself and/or my dependents, and by making this request, I understand and agree that (regardless of the status of my insurance) I am ultimately responsible for deductible, copays, and any balance on my account for any professional services rendered to the insured of the above named person.

I authorize our caretaker(s) to sign at the time service is rendered as verification that service was indeed rendered. I accept financial responsibility for services verified in this manner.

I understand that all bills are payable and become due upon presentation. **Copay/Coinsurance is due at each visit unless prior arrangements have been made with our business office.**

ASSIGNMENT OF BENEFITS:
I hereby assign all medical 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 health/medical plan, to issue payment check(s) directly to **THE T.E.A.M. APPROACH** 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. I further agree to sign over to **THE T.E.A.M. APPROACH** any payment which might be received by me, in error, from my insurance carrier for services rendered to myself and/or my dependents.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize **THE T.E.AM. APPROACH** to: (1) release any information necessary to insurance carriers regarding my or my dependent's condition and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

_____	_____
Name of Parent or Responsible Party	Relationship to Child
_____	_____
Signature of Parent or Responsible Party	Date