Psychological Health Services
Jessica Snyder, LCP
Authorization of Benefits and Authorization for Release

Assignment of Benefits and Authorization for Release

Private Insurance companies and government insurance programs such as Medicare and Medicaid require you to sign an assignment of benefits for us to bill your insurance company directly. For this reason, the clinic requires your consent to release medical information to your insurance company and any other parties cooperating in the delivery of your care.

Assignment of Insurance Information:

I hereby authorize assignment of benefits and payment of medical/mental health benefits to Psychological Health Services-Jessica Snyder, LCP for services rendered to myself and/or other dependents. I agree to be responsible for payment of any co-pay charges and any balance due for charges not covered by my insurance policy. I understand that co-pays are due at the time of service and any additional charges are due in full upon receipt of my first statement. I authorize my insurance company to credit me for any overpaid benefits. These credits will be applied toward my sessions or to me directly at the end of treatment. By signing this form, I recognize that my protected health care information (PHI) may be released for treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made by my prior consent. I recognize that if I do not consent to release my PHI for the above purposes I will not be denied treatment, but the provider may not be able to utilize my insurance for payment.

Authorization for Release of Insurance Information

I hereby authorize Jessica Snyder or authorized staff of Psychological Health Services to contact my insurance company directly to obtain coverage and payment information regarding my policy.

This consent is given freely with the understanding that:

1. All records, whether written, oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as provided by law.
2. A photocopy or fax of this consent is as valid as the original.

Client Name: (Printed) _____

X _____

Client (or Guardian of under 18) Signature a...
Date

X _____

Jessica Snyder, LCP

Psychological Health Services
Jessica Snyder, LCP
Insurance Information (if applicable)

Insurance Company: _____

Is Jessica Snyder, LCP an in-network provider with your insurer □ Yes □ No

Name of Insured: _____
(First) (Middle Initial) (Last)

Insured's Birth Date: _____ /_____ /_____ Insured's SSN #:_____

Insured's Employer: _____

Insured's Relationship to the Client: _____

Policy Name: _____

Insured's Member ID #:_____

Insured's Group #:_____

Please review the back of your card or your policy information for the following information:

Customer Service Phone # (for MH/SA): _____

Address for Submitting Claims: _____

_____

*****As noted in the above Clinic Policies please print the Debit Card Authorization form (on the PHS web-site) to consent for a card number to be stored on file for fees not covered by your insurance provider. This is required. *****

Credit Card Pre-Authorization Form

I authorize __Psychological Health Services: Jessica Snyder, LCP_ to keep my signature on file and to charge the credit card selected below for the following:

Balance remaining after claim (s) is (are) resolved for:

- ☐ This consultation only
- ☐ All consultations this calendar year
- ☐ All consultations from _____ to _____

☐ **Recurring charges of $_____ to be charged every _____**
(frequency)

From _____ to _____
(date) (date)

☐ **Charges for the following family members:**
_____ _____
(authorized family member) (authorized family member)

Check One:
☐ Visa® ☐ American Express® ☐ MasterCard® ☐ Discover Card®

Patient Name:
_____

Cardholder Name:
_____

Cardholder Address:
_____

City: _____ **State:** _____ **Zip:** _____

Credit Card Number: _____
CVV (3 numbers on back of card**):** _____ **Exp. Date:** _____

Cardholder Signature: _____**Date**: _____