Healing Path Psychology, LLC
35 E Elizabeth Ave, Ste 26, Bethlehem, PA 18018
Phone: 610-320-2366

Name:_____ MR #:_____ Admit Date:_____

ASSIGNMENT OF BENEFITS / RELEASE OF MEDICAL INFORMATION

I hereby authorize and request that payment of benefits by my primary insurance company _____, and my secondary insurance (if any) _____ be made directly to Healing Path Psychology, LLC and it's staff for services furnished to me or my dependent. I understand that my insurance company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment.

In addition, I authorize Healing Path Psychology, LLC and it's staff to disclose any and all written information from the above named insurance company and/or its designated representatives, at the determination of Healing Path Psychology, LLC and it's staff. Such disclosure shall be for reimbursement purposes for those services received.

I hereby release Healing Path Psychology, LLC and it's staff, its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the above named insurance company(s) or their designated representatives.

By signing this assignment of benefits and release of information I acknowledge:

1.I am aware and understand that this authorization will not be used unless the above named insurance company(s) or their designated representatives request records of information for reimbursement purposes; or seek to take action reference payment for treatment services.
2.I agree to participate and assist Healing Path Psychology, LLC and it's staff or its designated representatives with any appeal process necessary to collect payments for services rendered.
3.I am aware and have been advised of the provisions of Federal and State Statues, rules and regulations and provide for my right to confidentiality of these records.
4.I understand that this assignment and authorization is subject to revocation at anytime except to the extent that action has been taken in reliance thereof. In any event, this authorization will expire once reimbursement for services rendered is complete.
5. Healing Path Psychology, LLC and it's staff is acting in filing for insurance benefits assigned to Healing Path Psychology, LLC and it's staff and it can assume no responsibility for guaranteeing payment of any charges from the insurance company(s).
6. A firm contracted by Healing Path Psychology, LLC and it's staff for billing and collection purposes may do billing.
7. Healing Path Psychology, LLC and it's staff is appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier. This includes receiving a copy of my insurance plan's documents.
8.Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.
9. Healing Path Psychology, LLC and it's staff shall be entitled to the full amount of its charges without offset. I acknowledge receipt of a completed and signed copy of this assignment and release form.

_____	_____	_____
Signature of Patient	Printed name	Date
_____	_____	_____
Signature of Witness	Printed name	Date