AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE

Patient Name: _____ DOB: _____

For your own financial planning and protection, please check your eligibility and benefits with your insurance company to ensure accurate payment and coverage of mental health services. Some insurance plans require Pre-Authorization. Please be equally concerned about asking if this is a requirement for you, and if so, follow the protocol as directed by your insurance company. Your signature below also indicates that you understand that this Authorization Form is not a guarantee of coverage or payment by your insurance company, and if at any time your insurance company does not reimburse the contracted amount, you are responsible for paying the full fee for the service(s). Your payment portion is due at the time of service unless other arrangements have been made.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize **Azita Afshar, Psy.D.** to release to my insurance company any and all information they may require concerning patient care.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize payment by my insurance company directly to **Azita Afshar, Psy.D.**

PRE-AUTHORIZATION

I understand that it is my responsibility to contact my insurance company (by calling the number on the back of my insurance card) prior to my visits with **Azita Afshar, Psy.D.** in order to check eligibility and benefits as well as obtain any necessary pre-authorizations.

Patient signature: _____ Date: _____