Assignment of Benefits

In order to fully expedite benefits, this form must be completely filled out

Patient Information

Patient name:		
Social Security no.:	Date of birth:	Email address:
Address:		
City:	State:	Zip:
Home phone:	Work phone:	Cell phone:

Therapist Information

Therapist's name: Jacquelyn Schwartz	Phone:858-356-5839	
Address:11772 Sorrento Valley Rd. Suite 157		
City: San Diego	State: CA	Zip: 92121

Insurance Information

Insurance company:		Phone:	
Address:			
City:		State:	Zip:
Policy no.:		Group no.:	
Policy holder:		Date of birth:	
Relationship to patient:		Social Security no.:	
Employer:		Employer's phone:	
Employer's address:			
City:		State:	Zip:
Authorization:	# sessions:	Start date:	Expiration:

Patient Information Release Authorization and Assignment of Insurance Benefits

Please be aware that all medical information is confidential under certain state and federal laws. Such information may not be released without your consent. Many insurance carriers require medical information to be submitted with claims to evaluate medical necessity. Please provide your written consent to release related information when required or requested to your insurance company(s) and /or your healthcare team.

I,_____do hereby authorize Jacquelyn Schwartz, MFT to acquire from and /or release to my healthcare team and/or my insurance company(s), any information required for the purposes of healthcare management and /or for processing all medical claims on my behalf. I understand that upon acceptance, I assume responsibility for any deductible, copay, or other balance not covered by my insurance carrier. I authorize Jacquelyn Schwartz, MFT to submit claims to my insurance company on my behalf, and my insurance company to pay benefits directly to Jacquelyn Schwartz, MFT. Should any insurance payment be made directly to the insured for monies due on this account, I agree to immediately pay over these funds to Jacquelyn Schwartz, MFT. I will be informed of my insurance coverage and estimated out-of-pocket expense prior to any bills being sent.

Patient Signature:_____ Date:_____

Primary Policy Holder Signature:_____ Date:_____