COMPASSIONATE PATHWAYS COUNSELING

Finding Your Way Through

Assignment of Insurance Benefits

Insurance Information:

Insurance Company_____ Policy #_____

Group #_____ Telephone _____

Subscriber Name_____ Date of Birth _____

I, _____ (client name) hereby give my consent for Compassionate Pathways Counseling to bill my insurance company_____ (insurance company name), for services rendered to me by Mandy Schulzke, LPC. I authorize my insurance company to pay benefits directly to:

Compassionate Pathways Counseling
Mandy Schulzke, LPC
17505 N 79th Ave, Ste 213
Glendale, AZ 85308

I understand:

- Compassionate Pathways Counseling will make best efforts to collect from insurance companies, but cannot guarantee that the insurance company will pay all charges.
- All co-pays are due at the time of service and that I am personally and fully financially responsible for all charges whether or not they are paid by my insurance.
- Some third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. This information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health diagnosis.
- I am responsible for notifying Compassionate Pathways Counseling of any changes in my insurance.
- I understand that. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

I hereby authorize Compassionate Pathways Counseling to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions.

Client/Parent Signature_____Date_____

Printed Name_____