

COUNSELING AND COPING STRATEGIES, LLC
AUTHORIZATION OF INSURANCE ASSIGNMENT

I authorize Counseling and Coping Strategies (CCS), LLC, to apply for benefits to Medicare and/or my insurance carrier, on my behalf, for covered services provided by her practice. I request that the payments for these covered services from Medicare and/or my insurance carrier be made directly to CCS.

I understand that this provider may use or disclose the protected health information (PHI) or medical information only as allowed by my signed consent
For purpose of treatment, payment and healthcare operations, and needed to determine the payment of these benefits, or the benefits payable for related services, to my insurance carrier of the Centers for Medicare and Medicaid Services (CSM) or its agents.

In Medicare assigned cases, this provider agrees to accept the charge determined by the Medicare carrier as the full charge and the patient is responsible for the deductible, co-insurance and uncovered services.

I understand that my signature requests that payment be made to this provider. I permit a copy of this authorization to be used in place of the original.

In event that my insurance company does not pay any claim, or if my insurance coverage does not apply, I am ultimately responsible for payment of fees for rendered services.

I certify that the information I have reported with regard to my insurance coverage is correct. This authorization may be revoked in writing, by either my insurance carrier or myself at anytime.

I have read and understand the above information and agree to the terms of this authorization, as evidenced by my signature below.

(Print Name of Patient or Personal Representative)

Date: _____

(Signature of Patient or Personal Representative)

Description of Personal Representative Authority: _____