BARBRA ROGOFF, LCSW
Psychotherapist

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CLIENT'S AUTHORIZATION TO BILL
INSURANCE AND ASSIGNMENT OF BENEFITS

Client's Name: _____

Primary Insurance Information

Insurance Company: _____

Identification #: _____ Group #: _____

Provider Services Phone # (on back of card): _____

Mental Health Plan (if different): _____

Identification #: _____ Group #: _____

Provider Services Phone # (on back of card): _____

Please inform me if you have secondary insurance and a second form will be sent to you to complete.

☐ MEDICARE

In signing below, I request that payment of authorized Medicare benefits be made either to me or on my behalf to: *Barbra Rogoff, LCSW* for any services furnished me by the provider. I authorize provider to release to the Social Security Administration and Centers for Medicare & Medicaid services or its intermediaries or carriers any information needed to identify me, to determine eligibility, to decide if the services received are covered by Medicare and to insure that proper payment is made. I understand this may include health information pertaining to psychiatric, drug and alcohol abuse conditions, AIDS, AIDS-related conditions, or HIV if required. If "other health insurance" is indicated in item 9 of the HCFA 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the client is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination and carrier.

☐ PRIVATE INSURANCE, MEDICAID AND OTHER HEALTH PLANS OR THIRD PARTY COVERAGE NOT MEDICARE

In signing below I hereby assign medical benefits, including those from government-sponsored programs and other health plans or third party coverage, to be paid to *Barbra Rogoff, LCSW* for any services provided to me by the provider. I authorize provider to release any information needed to identify me, to determine eligibility, to decide if the services received are covered and to insure that proper payment is made. I understand this may include health information pertaining to psychiatric, drug and alcohol abuse conditions, AIDS, AIDS-related conditions, or HIV if required. I understand that I am responsible for any deductible, coinsurance, and/or non-covered services. Coinsurance and the deductible are based upon the charge determination and carrier.

I understand my signature requests that payment be made and authorizes the release of medical information about me necessary to support any insurance claim and secure timely payments due to the assignee or myself. I permit a copy of this authorization to be used in place of the original.

Signature of Client

Date

Signature of Client/Guardian (if applicable)

Date