PINECREST
COUNSELING

SIGNATURE ON FILE AND ASSIGNMENT OF BENEFITS AGREEMENT

Kindly accept a photocopy of this agreement as if were original executed authorization. I understand that Iris More, LCSW, Pinecrest Counseling utilizes computerize billing; therefore, my signature below acts as a signature on file. I authorize the release of any payment and medical information necessary to process my/or my family member's claim and related claims.

Signed: _____ Date: _____

I hereby authorize payment directly to Iris More, LCSW, Pinecrest Counseling, for the insurance benefits otherwise payable to me for professional services. I understand that I am financially responsible to Iris More, LCSW, Pinecrest Counseling, for changes not covered by this agreement.

Signed: _____ Date: _____

In the event that my insurance company fails to meet its obligations with respect to payment of my claim, I give my permission for Iris More, LCSW, Pinecrest Counseling to send a complaint to the State Insurance Commissioner using my name as the complaint. I also understand that I will be informed, in writing, if this occurs.

Signed: _____ Date: _____

I am aware that in the event I am unable to attend my appointment I must give 24-hour notice, otherwise I will be responsible for the full payment. Notification can be made by phone or website contact.

Signed: _____ Date: _____

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