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 benefits otherwise payable to me for professional serv responsible to Iris More, LCSW, Pinecrest Counseling, f	ices. I understand that I am financially
Signed:	Date:
In the event that my insurance company fails to meet in claim, I give my permission for Iris More, LCSW, Pinecr State Insurance Commissioner using my name as the coinformed, in writing, if this occurs.	est Counseling to send a complaint to the
Signed:	Date:
I am aware that in the event I am unable to attend my otherwise I will be responsible for the full payment. No contact.	
Signed:	Date: