Forest Licensed Clinical Social Work, PC
1115 Ellsworth Blvd
Malta, NY 12020

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize my insurance company (whose I.D. card and/or information I have given to this provider) and their review agencies to make payment directly to Forest Licensed Clinical Social Work PC, for services rendered to me. I understand that these are medical benefits otherwise payable to me for treatment rendered by Forest Licensed Clinical Social Work PC. I agree that the assignment of benefits statement shall remain valid until the account has been paid in full.

Guarantor Initials_____

RELEASE OF INFORMATION/PRIVACY POLICY (HIPAA COMPLIANCE):

I hereby authorize release of information necessary in the processing of payment for my treatment rendered by Forest Licensed Clinical Social Work PC. This authorization includes release of information to my insurance carrier, its utilization review organization, and/or parties involved in the processing of payment for my treatment. Such other parties are also known as "business associates."

I understand that I need NOT consent to the release of information in order to obtain services. I choose to do so willingly voluntarily for the purpose specified above. I understand that I may revoke this consent at any time by notifying Forest Licensed Clinical Social Work PC in writing, except to the extent that action has been taken in reliance on my consent. For any releases of information OTHER than the ones referenced above, a separate authorization must be obtained. By signing below, I acknowledge my understanding of this provider's privacy policy, and consent to the use and disclosure of my protected health information as outlined above.

Guarantor Initials_____

_____ _____

Printed Name of Insured Signature of Insured

_____ _____

Printed Name of Patient Signature of Patient

_____ _____

Printed Name of Witness Signature of Witness

_____

Date