Timothy S. Cahn, Ph.D.
Clinical Psychology
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PLEASE NOTE ALL 3 AREAS MUST BE SIGNED IN ORDER FOR OUR OFFICE TO BE ABLE TO BILL YOUR INSURANCE COMPANY

AUTHORIZATION TO BILL INSURANCE

I,_____,hereby give my

consent for _____ to bill my insurance
(Name of Provider)
company _____ for services
(Name of Insurance Company)
rendered to me by the above mentioned health care provider.

PATIENT SIGNATURE:_____

ASSIGNMENT OF BENEFIT

I authorize the above mentioned insurance company to pay medical benefits directly to the above

mentioned health care provider.

PATIENT SIGNATURE:_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize, _____ to release necessary medical
(Name of Provider)
information to the above mentioned insurance company and/or to their designated managed

care company, _____, as is required by my
(Name of Managed Care Company)
insurance company to process my insurance claims.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

Date: _____

PATIENT SIGNATURE:_____

SS#:_____DOB:_____

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