ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to this agency for mental health treatment benefits otherwise payable to me but not to exceed this agency's regular charges for this service and period. Although eligibility and benefits information will be corroborated to the best of the agency's ability, certification for medical necessity does not guarantee reimbursement related to these matters.

I understand that it is my responsibility to resolve any dispute with my insurance carrier or third party payer and that I am obligated to pay all charges in the mean time. In the event of default in payment, I will be held liable for the unpaid balance, including any attorney or collection charges as permitted by law.

In order to process my claims or benefits, I authorize this agency to release to my insurance carrier or third party payer I may have, as well as to an administrator, utilization review organization or fourth party payer appointed by them, any information regarding my treatment program that may be required. I also authorize this agency to contact the Washington State Insurance Commissioner on behalf of my insurance claim, if my insurance carrier sees fit to deny charges for treatment.

___________________________________	___________________
Patient Name	Patient ID Number
___________________________________	___________________
Policy Holder Signature	Date
___________________________________	___________________
Staff Signature	Date