AUTHORIZATION FOR RELEASE OF INSURANCE INFORMATION:

Private insurance companies and governmental insurance programs such as Medicare and Medicaid, require you to sign an assignment of benefits in order for me to bill your insurance company directly. State Law requires a signed patient consent to release medical information to your insurance company and any other parties cooperating in the delivery of your care.

ASSIGNMENT OF INSURANCE INFORMATION:

I hereby authorize assignment of benefits and payment of medical/mental health benefits to Catherine C. Olson, MSW, LICSW, LCSW for services rendered to myself and or other dependents. I agree to be responsible for payment of any co-pay charges and any balance due for charges not covered by my insurance policy. I understand that co-pays are due at the time of services and any additional charges are due in full upon receipt of my first statement. I authorize refunds to my insurance company for any overpaid benefits.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent

AUTHORIZATION

I hereby authorize *Catherine C. Olson, MSW, LICSW, LCSW* to contact my insurance company directly to obtain coverage and payment information regarding my policy.

This consent is give freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.

2. A photocopy or fax of this consent is as valid as this original.

Name (printed) ____

Signature ______________________________________Date_______