Dr. Bergin
Family Counseling Services

ASSIGNMENT OF & AUTHORIZATION TO PAY MEDICAL EXPENSE BENEFITS

Policy Holder _____

Client _____

Insurance Company _____

I hereby authorize payment directly to Dr. A. Bergin, LMFT for all professional expense benefits payable to me but not to exceed the reasonable and customary charges for this service. I understand that I am financially responsible for any amounts that are not paid through my insurance company.

If policy specifically prohibits assignment, make check payable to BOTH subscriber and therapist and send directly to therapist.

NOTE: Under California law, payment by an obligor to a person other than the assignee after notification of assignment may result in liability to the obligor to repay the amount.

I further hereby authorize the release of information to the insurance company that may be pertinent to the processing of billing claims.

_____ _____
Signature Date

_____ _____
Signature Date

Address _____ City/Zip _____