AMERICAN
PSYCHIATRIC GROUP

ASSIGNMENT OF BENEFITS FORM

Client Name: _____ D.O.B. : _____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to American Psychiatric Group., for any services provided to me by this organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier, or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity, if requested. The original will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for products and services received.

We understand that if your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with American Psychiatric Group, please give us at least 24 hours' notice. If you do not cancel or reschedule your appointment with at least 24 hours' notice, we may assess a **$45.00** "no-show" service charge to your account. This "no-show charge" may not be reimbursable by your insurance company. You will be billed directly for it.

Signature of Client _____ Date: _____

Signature of Custodial Parent or Guardian _____ Date: _____