B. Beth Cohen, Ph.D., Licensed Psychologist, PLLC
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One day per week at:
JRD Psychological Services
371 W. Church St.
Elmira, NY 14901

Insurance Information and Medical Assignment

I have read, or had read to me, the sections of Dr. Cohen's office policies dealing with fees, health insurance, and financial arrangements. I have had the opportunity to discuss, consider, and decide whether to use health insurance or pay privately for Dr. Cohen's services. I am indicating my decision by checking one of the two boxes below, and by my signature below that.

❑ I will pay for Dr. Cohen's services privately (i.e., out of my own pocket). I agree to pay Dr. Cohen according to the fees and financial arrangements in the document "Client Information and Policies."

❑ I will use my health insurance for Dr. Cohen's services. I have completed the sections below my signature.

____
Client name (please print)

____
Name of responsible party and relationship to client (please print)

____ __________________
Signature of client or other responsible party Date

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Assignment of Benefits:

- I give this office permission to release any information about this client that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.
- I hereby authorize Dr. Cohen and her staff to discuss insurance and billing issues with the health insurance policy holder if the insurance is not in my name.
- I understand that I am financially responsible for any unpaid balance including co-pays, co-insurance, deductibles, and any services not covered under my insurance including business interruption fees, late fees, and collections fees.
- I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to B. Beth Cohen, Ph.D. (In other words, I hereby authorize my benefits to be paid directly to Dr. Cohen.) Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.
- I have completed the sections below to enable Dr. Cohen to bill my insurance. I am aware that I am placing my signature on file.

How does insurance co. identify the client? Name: ____________________________ Gender marker: M❑ F ❑

Primary Insurance Co: ____ ID # __________________________

Policy Holder's Name: ____ Policy Holder's DOB: ___/_____/_____

What is client's relationship to the insured? Self ❑ Spouse ❑ Child ❑ Other ❑

Is the insurance under the policy holder's employer? Yes ❑ No ❑ Employer's Name: ____________________________

Secondary Insurance Co (if any):____________________________________ ID # __________________________

Policy Holder's Name: ____ Policy Holder's DOB: ___/_____/_____

What is client's relationship to the insured? Self ❑ Spouse ❑ Child ❑ Other ❑

Is the insurance under the policy holder's employer? Yes ❑ No ❑ Employer's Name: ____________________________