Christina R. Perkins, LCSW
4877 Chambliss Ave
Knoxville, TN 37919
P: (865) 924-2558 F: 866-768-6708

Authorization for Release of Information for Assignment of Benefits

I request that Christina R. Perkins, LCSW, file claims on my behalf with my health insurance company and/or managed care organization for behavioral health services rendered to me or to a member of my family. I authorize Christina R. Perkins, LCSW, and/or her billing agent Wendy Rhodes, CPC, CPC-H, CPMA, to contact my health insurance company and/or managed care organization to verify my coverage and to obtain benefit information.

_____

Primary Insurance Company/Managed Care Organization Name

I understand that my insurance company and/or managed care organization may require information about my treatment in order to process the claim, and that this includes diagnosis, background information, progress notes, and/or treatment plans. I further authorize Christina R. Perkins, LCSW, and/or her agent Wendy Rhodes, CPC, CPC-H, CPMA, to release this information to my insurance company and/or managed care organization as needed to process those claims.

I assign payment to Christina R. Perkins, LCSW, for services provided. This includes all applicable benefits that would otherwise be payable to me. I understand that this amount is not to exceed the regular charge for services.

I understand that I am financially responsible for any charges not covered by my insurance company (including charges for missed appointments and cancellations with less than 24 hours' notice). If I am in default in payment for my contribution to the cost of treatment, costs of collections services will be added to my account.

I understand that I may revoke this release any time in writing. Any release which has been made prior to the receipt of my written revocation and which was made in reliance upon this authorization shall not constitute a breach of my confidentiality. This release is good from the date below until my written revocation.

I have read and understand the above policies. My signature below indicates my full and informed consent to abide by the billing practices described.

Client/Guardian Name: _____

Client/Guardian Signature: _____ Date:____/____/____

Therapist Signature: _____ Date:____/____/____