



## Please Read Carefully and Complete

I have read the Policy and Procedures and understand and accept the policies described previously I would rather:

Δ Pay each visit in full due to having out of network insurance (and file my own insurance)

Δ Pay my BCBS/Medcost/Optum Behavioral Health/Medicare copay and other fees for each session and have my insurance filed for me

Δ Self-pay due to not having insurance

Δ Self-pay due to a high deductible insurance plan (and no insurance will be filed)

Patient Name Printed: \_\_\_\_\_ Date: \_\_\_\_\_

Patient or Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Insurance Authorization

IN ORDER TO FILE YOUR INSURANCE FOR YOU, WE REQUIRE THAT YOU CHECK EACH BOX AND SIGN THE FOLLOWING SIGNATURE ON FILE FORM

- Δ I authorize use of this form on all my insurance submissions.
- Δ I authorize release of information to all my insurance carriers.
- Δ I authorize that I am responsible for my bill.
- Δ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carrier.
- Δ I authorize payment directly to my doctor or health care provider, and hereby assign my right to reimbursement for services rendered to Ricardo Bierrenbach MD.
- Δ I permit a copy of this authorization to be used in place of the original.

Patient or Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_