CLEAR HARBOR COUNSELING
INSURANCE AUTHORIZATION

Assignment of Benefits

I hereby authorize all insurance, Medicare or Medicaid benefits, or benefit payments from other sources for claims for services at Clear Harbor Counseling to be paid directly to CHC for therapy services. I agree to pay the balance due for any services received that are not covered by insurance.

Authorization for release of information to insurance providers

I authorize disclosure of my protected health information for the purpose of payment.
I understand that I am under no obligation to authorize the release and that Clear Harbor Counseling will not withhold treatment from me.

- I authorize release of claim form information to all my insurance companies
- I authorize release of treatment reports (written and/or verbal) as requested by my insurance company or MCO.
- I authorize use of this authorization on all my insurance submissions.
- I permit this signed authorization to be used in place of the original.

I understand I have the right to revoke this authorization at any time in writing. I am aware my revocation will not be effective if: (1) this authorization was obtained as a condition for obtaining insurance and applicable law permits the insurer to contest the claim or the policy itself; or, (2) to the extent the treating therapist and/or CHC has already acted in reliance upon this authorization. A typed signature below is considered the same as a written signature and will suffice for authorization.

Primary Insurance Company

Policy holder name DOB

Relationship to policy holder

Insurance ID Group ID

Client/Guardian Signature **Date Signed**