WOMEN'S & CHILDREN'S CENTER FOR MENTAL WELLNESS

PSYCHIATRY
7591 Fern Avenue,Suite1705,Shreveport, LA 71105
T (318) 550-3398 **F** (318) 550-3481

ASSIGNMENT OF BENEFITS

I hereby assign to Women's & Children's Center for Mental Wellness my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid, in my name or on my behalf. I further authorize payment of benefits directly to Women's & Children's Center for Mental Wellness. I understand that I am responsible for satisfying the pre-certification requirements for any policy of insurance, self-insured health plan, or government plan covering services provided by Women's & Children's Center for Mental Wellness.

I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for medical services and that I am financially responsible for all charges whether or not they are covered by my health insurance.

Patient Signature: _____ **Date:** _____

Patient Printed Name: _____

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____