

Priscilla Brinkman, LCSW, FT
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Assignment of Benefits / Agreement for Payment

I HEREBY AUTHORIZE payment to be made directly to Priscilla Brinkman of any insurance benefits covering my care. I understand as signee I am financially responsible to Priscilla Brinkman for all charges that are not covered by my insurance company.

I give Priscilla Brinkman permission to release any information obtained during examinations or treatment of this patient that is necessary to support any insurance claims on this account.

SIGNED: _____ Date: _____