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INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with____________________☐ primary insurance ☐ secondary insurance

Insurance ID _____________________ Group ID______________________SS # _________________________

and I assign directly to Sofia R. Tuchapsky, RN, LMHC all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

Sofia R. Tuchapsky, RN, LMHC may use my health care information and may disclose such information to the above named Insurance Company/Companies and their agents for the purpose of determining insurance benefits and obtaining payment for services. This consent will end when my current treatment is completed.

Patient's Name:_____________________________________ Date:_____________________

Patient's Signature: _________________________________ Relation to Insured: _________________________

Name of Policyholder (if it is not you):____

Date of Birth:__________________________ Telephone:__________________________________

Address: ____

City/State:___________________________________ Zip:___________________