Medical Release and Assignment of Benefits:

I authorize the release of any medical or other information necessary to process insurance claims for services rendered to me, or my dependents by _____

I also authorize payment of medical benefits to _____for psychotherapeutic services.

Signature _____ Date: _____
(Guardian if patient is under 18)

It is my (patient/parent or guardian) responsibility to know my insurance benefits. Therefore, I am responsible for any non-covered services rendered to my dependent or me. I agree to pay any co-payments, deductibles as established by my insurer.

Signature _____ Date: _____
(Guardian if patient is under 18)

Cancellation Policy

I understand that I am personally responsible for the fee for any appointment cancelled with less than 24 hours, or one business day's notice. This fee is my personal responsibility and cannot be billed to my insurance company.

Signature _____ Date: _____
(Guardian if patient is under 18)

Authorization to Release Confidential Information

I authorize Burlington Psychological Associates to disclose and make available information regarding my mental health status to my insurance company in written form or verbally for the purposes of reimbursement. In understand that this information may include, but is not limited to the following categories: clinical diagnosis; details of psychosocial history and description of my present functioning; dates of service, treatment plans and goals.

I recognize that Burlington Psychological Associates cannot guarantee the confidentiality of my records when they are released to third party payers. I understand that this data may remain in a data bank, which could be called upon at some future time when I apply for another health insurance policy, life insurance policy, or disability insurance policy.

_____ Date: _____
(Signature of person/guardian releasing information)

Burlington Psychological Associates
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