INSURANCE INFORMATION
Please Print

Client Name:_____ Date of Birth:_____

Name of Insured (if different):_____ Date of Birth:_____

If Client is a minor, Name of Parent,
Guardian or Authorized Representative:_____ Date of Birth:_____

Name of Primary Insurance Company:_____

Insured's I.D. #:_____ Group #:_____

Name of Secondary Insurance Company (if any):_____

Insured's I.D. #:_____ Group #:_____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my therapist to submit claims for benefits for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____hereby authorize_____

Name of Insured (or Parent, Guardian or Authorized Representative of Insured) — Name Of Insurance Company

to pay and hereby assign directly to Arthur Rosenthal, MFT all benefits, if any, otherwise payable to me for his professional services. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Arthur Rosenthal, MFT will be credited to my account in accordance with the above assignment.

_____ _____

Signature of Subscriber (or Parent, Guardian or Authorized Representative of subscriber) — Date