DEBRA M. DALBY, L.C.S.W.
208 South King Street, SW Suite 202
Leesburg, Virginia 20175

ASSIGNMENT AUTHORIZATION

Client Name: _____ Phone #_____
Client Address: _____

I hereby authorize Debra Dalby, LCSW to evaluate and provide treatment to me. I authorize this Therapist to apply for benefits on my behalf for covered services provided by this Therapist and request that payments from my insurance carrier be made payable directly to this Therapist.

I certify that the insurance information I have provided is correct. I also authorize release of necessary information to the insurance carrier billed for those services in order to determine benefits to which I may be entitled. I permit a copy of this authorization to be used in place of the original. My insurance carrier or I may revoke authorization at any time in writing.

I understand and agree that I am financially responsible for any charges not paid for by my insurance carrier. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree that jurisdiction for said collection shall be Loudoun County, Virginia and the cost of collection will be included in the claim.

Co-pay is requested at the time of each appointment.
I understand that I may be charged a full session fee for appointments that are cancelled with less than a 24-hour notice. Additionally, I understand that this Therapist cannot bill my insurance for the cancelled appointment.

PRIMARY INSURANCE INFORMATION

Client Name: _____ Date of Birth: _____
SS# _____
Insurance Company:_____ Phone #:_____
Address: _____ Phone #:_____
_____ Policy #: _____
Plan/Group #: _____

Subscriber Name: _____ Subscriber ID#: _____
Subscriber SS#: _____ Date of Birth: _____
Client Relationship to subscriber: ___Self ___Spouse ____Child ____Parent ____Other
Guarantor (person responsible for payment if other than client): _____
Any Other Insurance: **YES_____ NO _____**
Employer Name: _____ Home Phone #: _____
Address: _____ Work #: _____
_____

I, the undersigned, have read and understood the above, and verify that the above information is true and correct.

Signature of the Client: _____ Date: _____

Witness: _____ Date: _____

Form: 08/08/2013