ASSIGNMENT OF BENEFITS

I, _____ hereby authorize any insurance carrier under which benefits are due the below patient, to assign payment directly to the C. Snyder Counseling & Wellness, LLC. For any claim regarding (patient's name) _____ Relationship to insured_____

I additionally authorize the release of any relevant and/or pertinent clinical/medical/psychological information necessary to process my insurance claims.

Signed _____ Date _____

CHARGE FOR SERVICES AGREEMENT

I have been informed that there will be a charge for any appointment that I schedule and then break or cancel within 24 hours of the scheduled appointment. I understand that these appointments will be recorded in the office notes as cancelled or broken and I will be personally responsible for the payment of these charges in full. If the patient is a minor under my guardianship, I also accept full responsibility for payment of any cancelled or broken appointments. I acknowledge and understand that I am responsible for all of the charges of all the services rendered me and/or any member of my family. This responsibility includes the payment of all co-payments and full payment for services rendered which are uncovered by any insurance plan under which I have covered medical benefits. I agree to pay for all services as rendered at time of service or within one month of receiving a bill.

Signed _____ Date _____

HIPPA OUTPATIENT SERVICE CONTRACT

I have read/received/ or was offered a copy of the HIPPA Outpatient Service Contract. Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Signature _____ Date _____

Printed Name: _____

3606C Nicholas Street, Easton, PA 18045 484-819-0771