

SAMANTHA SLAUGHTER, PSYD

AUTHORIZATION TO BILL INSURANCE

I, _____, hereby give my consent for Samantha Slaughter, PsyD to bill my insurance company, _____, for services rendered to me by Samantha Slaughter, PsyD.

Signature: _____ Date: _____

ASSIGNMENT OF BENEFIT

I authorize my insurance company, _____, to pay medical benefits directly to Samantha Slaughter, PsyD.

Signature: _____ Date: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Samantha Slaughter, PsyD to release necessary medical information at my insurance company and/or to their designated managed care company, _____, as is required by my insurance company to process my insurance claims.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

Signature: _____ Date: _____

SS#: _____ DOB: _____

Witness Signature: _____ Date: _____