illuminate
THERAPY & WELLNESS

Assignment of Insurance Benefits

Mental health benefits are reimbursed differently than general medical benefits, thus it is important that you verify your health plan prior to your initial appointment. Please contact your insurance provider to address questions directly.

I hereby authorize Illuminate Therapy & Wellness, LLC to release the necessary information to file any insurance claims on this account. I hereby authorize all benefits payable directly to Illuminate Therapy & Wellness, LLC. I understand that I am financially responsible for all the charges incurred for services rendered to me and I hereby agree to pay all charges regardless of insurance coverage. Payment is expected at the end of each session.

Name of Client: ______________________

Name of Insured (if different from Client): ______________________

Insured Date of Birth: ______________________

Relationship: ☐ Self ☐ Spouse ☐ Dependent

Insurance Provider: ______________________

Member ID: ______________________

Group Number: ______________________

Your signature is necessary in order for Illuminate Therapy & Wellness, LLC to submit your claims to your insurance provider. I authorize the use of this signature on all insurance submissions. I authorize the release and use of information required to collect outstanding charges on this account. I have read this information and agree.

Client Signature. ______________________ Date: __________

(Client if 12 years or older)

Parent/Guardian Signature ______________________ Date: __________

(Parent/Guardian if Client is Minor under 12 years of age/Personal Representative)

Witness Signature ______________________ Date: __________