PATIENT'S AUTHORIZATION

I authorize the release of any medical information necessary to process this claim to Medicare, Blue Cross/Blue Shield or Maryland, and/or other insurance carriers named by me. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me, or the named carrier(s), at any time in writing. I understand that the Health Care Financing Administration (HCFA) is the government Medicare Program.

_____ _____
SIGNATURE DATE

_____ _____
LEGAL GUARDIAN OR DATE
INSURANCE SUBSCRIBER (WITNESS)

AUTHORIZATION TO PAY BENEFITS

I request that payment of authorized Medicare, Medical Assistance, Blue Cross/Blue Shield of Maryland, other insurance named by me, and/or Medigap benefits be made on my behalf to Dr. Dean R. Kirschner, Ph.D., LCSW-C, for any services furnished to me. I authorize a holder of medical information about me to release to Health Care Administration and its agents and/or other insurance carries as named by me, any information needed to determine those benefits or benefits payable for related services. I authorize the payment of insurance benefits to be made out to Dr. Dean R. Kirschner, Ph.D., LCSW-C for any services furnished to me. I authorize any holder of medical information about me to be released to

_____
(Name of insurance company)
any information needed to determine these benefits or benefits payable for related services.

_____ _____
SIGNATURE DATE

_____ _____
LEGAL GUARDIAN OR SUBSCRIBER DATE

AUTHORIZATION

I understand I am responsible for paying the portions due according to the contract of my insurance carrier, including all co-payments and deductibles. If no insurance exists, whether due to lapse/or termination of coverage or simply lack of coverage, I understand I am financially responsible for all charges of services performed for me, or my legal dependent. I also understand that in the event that default of payment occurs, I will be responsible for all costs incurred by this office to secure proper payment, including but not limited to attorneys fees, court cost and interest.

_____ _____
NAME (PRINT) DATE

_____
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE