Kristina Vande Vrede, PsyD
WOMEN'S MENTAL HEALTH & PERINATAL SPECIALIST

ASSIGNMENT OF BENEFITS FORM

Client Name:_____

I authorize Dr. Vande Vrede to file insurance claims on my behalf. I authorize any information, medical or otherwise, necessary to process these claim(s) to be released to Dr. Vande Vrede. I authorize Dr. Vande Vrede to act on my behalf and report any violations of proper claims practices to the proper regulatory authorities.

The assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

Authorization allows Dr. Vande Vrede to release to the insurance company any information related to processing claims including but not limited to treatment plan, progress and diagnosis.

Client signature: _____
(Authorized person or guardian's signature if client is a minor)

Date: _____