LESLIE ELLEN ACKERMAN, PSY.D., PC

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Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Leslie Ackerman, Psy.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance and/or for the services not covered by insurance. I hereby authorize Leslie Ackerman, Psy.D. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible party signature **Relationship** **Date**