Mabel López, Ph.D.
Licensed Clinical Psychologist, PY7375/ Neuropsychologist
10175 Six Mile Cypress Parkway, Suite #3
Fort Myers, FL 33966
(239) 768-6500 (Office) ♦ (239) 768-6421 (Fax)

ASSIGNMENT OF BENEFITS FORM

Practice Name: Mind and Brain Care, LLC
Address: 10175 Six Mile Cypress Pkwy, #3
City, State, Zip: Fort Myers, FL 33966 Telephone: 239-768-6500

Patient: _____ Date: _____
Employer: _____
Claim Group: _____
SSN#/ID#: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

Mind and Brain Care, LLC
6442 Commerce Park Dr., Ste. 1
Fort Myers, FL 33966

If my current policy prohibits direct payment to Doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Patient Name: _____
C/O Mind and Brain Care, LLC
10175 Six Mile Cypress Parkway, Suite #3
Fort Myers, FL 33966

for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Doctor to initiate a complaint to the Insurance Company for any reason on my behalf.

Dated at _____ this _____ day of _____, 20_____
(Time) (Day) (Month) (Year)

_____ _____
Signature of Policyholder Witness