ALLIANCE COUNSELING, LLC *David Clegg, EdD, MEd, LPC (AZ), LMHC (WA)*	
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RELEASE OF BENEFITS & INFORMATION

I authorize the release of any medical and other necessary information to process claims for counseling and related services. I also request payment of government benefits either to myself or the party who accepts assignment for services. I authorize Alliance Counseling LLC or DAVID CLEGG to be my personal representative, which allows Alliance Counseling, LLC or DAVID CLEGG to submit any and all appeals when my insurance company denies me benefits to which I am entitled, submit any and all requests for benefit information from my insurance company and initiate formal complaints to any state or federal agency that has jurisdiction over my benefits.

I fully understand and agree I am responsible for full payment of the medical debt if my insurance company refuses to pay 100 percent of my benefits within ninety (90) days of any and all appeals and requests for information. I agree any fines levied against my insurance company will by paid to Alliance Counseling, LLC or DAVID CLEGG for acting as my personal representative.

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Client's or Parent's/ Guardian's Signature Date