Frank D. Kohn, M.A., P.A.
Mental Health and Consultation Services
7191 Cypress Lake Dr., Suite 3 #1111
Fort Myers, Florida 33907
(239) 939-3911

Authorization to File Insurance on Behalf of Patient

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment below:

Signed_____ Date_____

I authorize payment of medical benefits to the undersigned physician or supplier for services rendered to patient.

Signed_____ Date_____

Provider: Frank D. Kohn, M.A., P.A.
Frank Kohn, MA, LMHC, CCMHC