



MARRIAGE & FAMILY THERAPY
of WESTERN NEW YORK

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I, the undersigned, authorize Marriage and Family Therapy of Western New York, PLLC to submit claims to my insurance company. If it is the case that my insurance company utilizes a managed care company, my therapist may need to discuss my treatment with a case manager. I understand that my confidentiality will be compromised in such a case. I realize that his/her doing so is a necessity in her effort to secure ongoing care.

I also authorize payment of medical benefits to Marriage and Family Therapy of Western New York, PLLC for services provided.

Patient Signature

Date

Insured Signature (If Different than Patient)

Date

Parent/Guardian Signature

Date