Jeanne M. Morris-Foley, N.P. Psychiatry P.C
4655 Nesconset Highway
Port Jefferson Station, N.Y. 11776

INSURANCE BENEFITS FORM

If you have no insurance benefits covering medical expenses, be sure to indicate "no" in the space proviced.

Do you have insurance coverage? YES _____ NO _____

Name of Insurance Company: _____

Adress of Insurance Company: _____

_____

Name and/or Number of Group: _____

Individual Policy Number: _____

Signature: _____

****

I hereby authorize Jeanne Morris-Foley, NP to release to the above insurance company all needed clinical information requested by the above company with respect to any treatment received by me (or my children) with Jeanne Morris-Foley.

_____ _____
Signature Date

****

I, _____ , hereby authorize assignment of my insurance benefits to:

Jeanne Morris-Foley, NP

If my insurance comopany does not assign benefits, I will sign over all such benefit checks to Jeanne Morris-Foley, NP as soon as I receive them.

_____ _____
Signature Date