**Collaborative Care Consultants**

**Assignment of Benefits Policy 2025**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# ASSIGNMENTOFBENEFITS

I hereby authorize direct payment to Collaborative Care Consultants (CCC) through its billing entity Inner Fire Wisdom Therapy and Consulting of any medical benefits payable to me for the services provided at Collaborative Care Consultants.

I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to appointment. I will be responsible for unpaid balance due on any bills.

**X**

**PATIENT SIGNATURE OR SIGNATURE OF GUARDIAN OR PARENT DATE**

# RECORDSRELEASE

I hereby authorize CCC to release my records to my insurance company and/or primary care physician for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as is dictated by the insurance payor.

**X**

**SIGNATURE OF PATIENT OR SIGNATURE OF GUARDIAN OR PARENT DATE**

**NOTICE OF PRIVACY PRACTICES**

My signature below indicates that I understand I have access to a copy of the Notice of Privacy Practices for CCC at any time by requesting a physical copy or viewing the Notice of Privacy Practices for CCC on the clinic’s website [*www.collaborative*](http://www.collaborative)*careconsultants.com*.

**X**

## PATIENT SIGNATURE OR SIGNATURE OF GUARDIAN OR PARENT DATE