**DAVID SIEGMAN, PSY.D.**

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INSURED’S OR AUTHORIZED PERSON’S SIGNATURE FOR:

1. ASSIGNMENT OF BENEFITS: I hereby authorize direct payment of insurance benefits to David Siegman, Psy.D. I understand that I am financially responsible for charges not covered by my insurance carrier

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. RELEASE OF INFORMATION: I hereby authorize David Siegman, Psy.D. to release to insurance carriers, representatives or insurance carriers, Medicare, Medicaid, government agencies and other guarantors any information needed to authorize treatment, process claims and effect payment.

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_