BRIGHTER DAY THERAPEUTIC SOLUTIONS, PLLC

12781 Darby Brook Court
Suite 202
Woodbridge, VA 22192
Phone: 703.494.0426
Fax: 703.494.1335
Email: althea.simpson@brighter-day.net

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with Brighter Day Therapeutic Solutions, PLLC. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all mental health and behavioral health benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Althea Simpson at Brighter Day Therapeutic Solutions, PLLC rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Althea Simpson to:

1. Release any information necessary to insurance carriers regarding my diagnosis and treatments.
2. Process insurance claims generated in the course of assessment, evaluation or treatment.
3. Allow a photocopy of my signature to be used to process insurance claims for the period of treatment.
4. This order will remain in effect until revoked by me in writing.

I have requested mental health/behavioral health services from Althea Simpson at Brighter Day Therapeutic Solutions, PLLC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

By signing below, you consent to the use, release and disclosure of your Protected Health Information (PHI) as specified above in this document and to the terms of this Informed Consent by which you agree to authorize treatment, payment and health care operations.

Client Name: _____ DOB: _____

_____ _____

Client/Responsible Party Signature Date