Licensed Marriage & Family Therapist, EMDR & TRM Certified, PACT Trained
C. Nathan Bergeron, LMFT (MFC 50298), L.Ac. (AC 8941)
Voice Dialogue Facilitator & Teacher, Licensed Acupuncturist & Herbalist

C. Nathan Bergeron, LMFT, L.Ac.
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AUTHORIZATION FOR PAYMENT FROM PRIVATE AND/OR GROUP INSURANCE

When covered by more than one carrier, please fill up a form for each insurance. Please list all numbers appearing on your card(s). Please note that it is your responsibility to check if: coverage requires a waiting period, is void for acupuncture, is void for psychological services, is contingent on a physician's referral, is contingent on an approval from the insurance carrier or plan, your deductible has been met, etc.

PATIENT INFORMATION:

Date:_____

First name:_____Mi:___ Last name:_____

Address:_____ City:_____ State:__ Zip:_____

Home:(____)_____ Work :(____)_____Cell:(____)_____

DOB:_____ Sex:_____ Age_____

❍ Minor, ❍ Single, ❍ Married, ❍ Separated, ❍ Divorce, ❍ In partnership, ❍ Other_____

INSURED INFORMATION IF DIFFERENT:

First name:_____Mi:___ Last name:_____

Address:_____ City:_____ State:__ Zip:_____

Home:(____)_____ Work :(____)_____Cell:(____)_____

SSN:_____ D.L.:_____ DOB:_____ Sex:___ Age___ Ht:___ Weight:____

INSURANCE INFORMATION:

❍ Aetna, ❍ Anthem Blue Cross, ❍ Availity, ❍ Blue Cross, ❍ Blue Shield, ❍ Cigna,
❍ Delta, ❍ Magellan, ❍ UHC, ❍ Writer's Guild, ❍ Other:_____

Insurance ID#:_____ **Group#**:_____

I hereby instruct and direct Mr. C. Nathan Bergeron to release the necessary medical and personal information so that my Insurance Company can reimburse Mr. Bergeron or myself; as established by the Super-Bill that I will provide them. Should Mr. Bergeron be entitled to reimbursement, check(s) shall be made out to, and mailed directly to him.

For professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charge for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. Payments will not exceed my indebtedness to the above mentioned assignee. I have agreed to pay in a current manner any balance or non-covered services and/or fees over and above the insurance payment, or as required by my insurance policy. I understand that my health Insurance carrier may pay less than the actual bill for services and therefore agree, when Mr. Bergeron is an "Out-Of-Network Provider" with my insurance company, to be responsible for payment of all services rendered on my behalf, or my dependents. A photocopy, or a phone picture of this assignment shall be considered as effective and valid as the original. In the case of a claim, I authorize the release of any information pertinent to my case to any insurance company adjuster or attorney involved.

_____ _____ _____ _____

Patient's Signature Date C. Nathan Bergeron, LMFT, L.Ac. Date