ASSIGNMENT OF BENEFITS

I, ____, hereby assign all benefits otherwise payable to me to TRA, as payment toward the balance due for medical services rendered to me. I further instruct and direct the ____ Insurance Company, Policy # _______________________________ and Group # _________________________________ to pay by check made out and mailed directly to:

THERAPY RESOURCE ASSOCIATES
10824 OLD MILL ROAD, SUITE #21
OMAHA, NE 68154

CANCELLATION POLICY:

I agree to **A MINIMUM OF 24 HOURS NOTIFICATION OF CANCELLATION** for appointments. I understand that **I WILL BE CHARGED FOR THE SESSION FOR MISSED APPOINTMENTS** without the minimum notification. I understand that my therapist will discuss repeated missed appointments with me.

Patient / Guardian / Policy Holder (signature) ____

Witness _______________________________

CONFIDENTIALITY:

Information or opinions can be given to others only with your written consent. There is an exception to this rule, however. When there is reason to believe a child has been abused or if a client threatens harm to himself/herself or others, the law requires that a report be made. If there is a possibility of present danger to himself/herself or others due to a client's history, a report may need to be made.

RELEASE OF INFORMATION:

I also authorize TRA to release any information pertinent to my case, including psychiatric and/or drug and alcohol treatment information, to any authorized representative of my insurance company, adjuster or review agency.

____	______________________	______________
Patient / Guardian / Policy Holder (signature)	Social Security #	Date