ASSIGNMENT OF BENEFITS FORM

WATERSHED WELLNESS

My signature below confirms that:

- I understand that my Watershed Wellness practitioner will be filing my insurance claims on my behalf as a courtesy. However, ultimately I am financially responsible for all charges on my account. I authorize my current insurance company to assign directly to Watershed Wellness all owed benefits.

- I understand billing insurance is a complex and sometimes complicated process, and after careful consideration Watershed Wellness has chosen third party billing agencies to process all claims. I authorize Watershed Wellness practitioners to disclose certain protected health information (PHI) to the third party billing company for the purposes of billing insurance under the guidelines of HIPAA (Health Insurance Portability and Accountability Act of 1996) and as otherwised described in Watershed Wellness' privacy policies.

_____

Client or representative name

_____

Client or representative signature

_____

If applicable, relationship of representative to client

_____

Date