New England Center for Healthy Minds

Assignment of Insurance Benefits

By my signature below, I authorize medical benefits to be paid to the New England Center for Healthy Minds on my or my child's behalf for any service provided by the medical and clinical staff of the practice.

I understand that I am responsible for all charges not covered by insurance for this service date and all future service dates.

_____	_____
Print Patient Name	Patient Date of Birth

_____	_____	_____
Signature of Patient/Parent/Personal Representative for Minor Child	Authority	Date