**Loving The Self Therapeutic Services LLC**

**Release of Information for Third Party Reimbursement**

I, _____, hereby authorize the mutual release/exchange

of information concerning myself/my minor child between Micheal Kane, Psy.D and

_____ as may be necessary for the following
Insurance Company

purposes only.

1. For use by insurance company(ies) for processing claims for treatment and/or for requesting the authorization of additional sessions, including the release of PHI, diagnosis and clinical information.

2. Other _____

Dr. Kane may bill the following insurance company(ies) and they may pay him directly.

Company: _____ ID No: _____

Group Number: _____

Company: _____ ID No: _____

Group Number: _____

I assign directly to Dr. Kane all medical benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance.

Parent/Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Micheal Kane, Psy.D: _____ Date: _____