Suzanne LeSure, Ph.D. and Associates Patient Information

Name	
Name DOB Social Security Number Address	
Address	
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Email	
address	· · · · · · · · · · · · · · · · · · ·
Name of insurance company	DOR
Policy holder name	DOB
Social security number	
Relationship	
Policy holder employer Group number Group number	
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Agreement, Assignment of Benefits, Assumption of Responsibility and Records transfer Authorization: I hereby assign to Suzanne LeSure, Ph.D. and Associates all benefits to which I am entitled from all private and public medical insurance plans including Medicare and Medicaid. I understand that I am financially responsible for all treatment charges for services rendered regardless of any limitations of insurance coverage. I understand that I may be charged for appointments missed unless 24 hour advance notice is given. I understand all deductibles and co-payments must be paid in full. I understand if my coverage is part of a contractual arrangement between Suzanne LeSure, Ph.D. and Associates and a specific third party payer, Suzanne LeSure, Ph.D. and Associates agrees to abide by the regulations and reduced rates outlined in those contracts. I agree to the above and authorize Suzanne LeSure, Ph.D. and Associates to release information about my condition and treatment as necessary to those who are part of the process of securing insurance payment for the same. I authorize payment to be made directly to Suzanne LeSure, Ph.D. and Associates. This assignment and authorization will remain in effect until revoked by me in writing. I acknowledge that a photo copy of this assignment and authorization is as valid as the original.	
Signature	
Printed name	

Please print and mail this form to:

Suzanne LeSure, Ph.D. 4475 Valley Forge Drive Cleveland, Ohio 44126

Alternatively, you may email this form to billing@suzannelesure.com.

Please be advised this method is less secure and Suzanne LeSure, Ph.D. and Associates are not responsible for any issues that may arise from you sending your private information via email.