Assignment of Insurance Benefits

I (the undersigned) hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes Maria Larkin, M.ED, RDN, LD of *Better Gut Better Health, LLC* to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though I had personally signed each claim.

Name of Subscriber _____

Date of Birth of Subscriber_____

Relationship of Subscriber to Client Self Spouse Parent/Guardian Other

I, _____ hereby
(Client Name)

authorize _____
(Name of Primary Insurance Company)

ID No: _____ Group No: _____

… to pay and assign directly to Maria Larkin, M.ED, RDN, LD of *Better Gut Better Health, LLC* all benefits, if any, otherwise payable to me for their services as billed to my insurance carrier. I hereby authorize Maria Larkin, M.ED, RDN, LD of *Better Gut Better Health, LLC* to release all information necessary to the Healthcare Financing Administration and its agents to secure the payment of benefits.

I acknowledge that any insurance benefits, when received by and paid to Maria Larkin, M.ED, RDN, LD of *Better Gut Better Health, LLC* will be credited to my account in accordance with the above assignment.

I certify that the insurance information I have provided is current and I will immediately notify Maria Larkin, M.ED, RDN, LD of *Better Gut Better Health, LLC* of any changes in my health insurance.

_____ Date: _____
(Authorized Signature: client, parent or legal guardian)

Better Gut Better Health, LLC
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