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AUTHORISATION FOR DIRECT BILLING

Client Name in Full: _____ Date of Birth: _____

Hereby assigns benefits payable from Company:

Policy #: _____

Group #: _____

In case of Second Company:

Policy #: _____

Group #: _____

Name of Planholder: _____

Plan holder Date of Birth: _____

To Maria Schmid, Registered Psychologist, and authorize payment directly to her.

I, _____ also understand and agree that any amount not covered by above Company and Policy are my personal responsibility to be paid to Maria Schmid.

Client Signature: _____ Psychologist Signature: _____

Date: _____