

**Palmwood Center for Psychological Services, P.A.**  
**8890 West Oakland Park Boulevard, Suite #103,**  
**Sunrise, FL 33351-7357**  
**Telephone (954) 742-7032 Fax (954) 742-7868**

**Alec Roth, Ph.D.**  
**Licensed Psychologist**

**Jonathan Pearlson, Psy.D.**  
**Licensed Psychologist**

**Marlene Gray, Psy.D.**  
**Licensed Psychologist**

**SIGNATURE ON FILE AND ASSIGNMENT OF BENEFITS AGREEMENT**

Kindly accept a photocopy of this authorization as if it were an original executed authorization and accept my signature below as my signature on file. I authorize the release of any payment and medical information necessary to process my or my family member's claim and related claims. I also request payment of government benefits to the Palmwood Center for Psychological Services, P.A.

Signed \_\_\_\_\_ Date \_\_\_\_\_

I authorize payment of medical benefits directly to the Palmwood Center for Psychological Services, P.A. I understand that I am financially responsible to the Palmwood Center for Psychological Services, P.A. for all charges not covered by this assignment.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Please note in your records that \_\_\_\_\_ is the only health insurance coverage I have. My spouse and I do not have other coverage.

Signed \_\_\_\_\_ Date \_\_\_\_\_

I understand that some insurance companies do not reimburse providers for court related treatment and/or services. No court involvement is, or will be required from the Palmwood Center for Psychological Services, P.A., it's employee's and/or it's officers. I further understand that I am financially responsible to the Palmwood Center for Psychological Services, P.A. for all court related charges not covered by my insurance company. I am hiring the Palmwood Center for Psychological Services, P.A. and/or its representatives as experts in the field of clinical psychology.

Signed \_\_\_\_\_ Date \_\_\_\_\_