Maria Schmid **B.A. M.Ed R.Psych**
Registered Psychologist
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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:_____