**John Cutrone, LMHC, LLC**
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**Phone: (561) 289-9722 Fax: (561) 544-7149 Website: www.CutroneLMHC.com**

# Insurance Plan Benefit Opt-Out Form

**Primary Insurance:** _____

**Secondary Insurance (if applicable):** _____

After reviewing my insurance benefits with Anthony Naguiat, LMHC, LLC (hereafter referred to as "the provider"), I have elected to NOT utilize my insurance benefits. I agree to pay the agreed upon fee out-of-pocket. I also understand that my insurance will not be billed, and that my fee will not go towards my deductible. I also understand that by opting out of using my benefits, no invoices or receipts (superbills) will be provided to me for services rendered to submit for reimbursement/apply to my deductible or out-of-pocket maximums.

This agreement is valid from the date of my signature below and shall expire upon the date on which I deliver written notice of termination to the provider. This authorization may be canceled in writing at any time. If I choose to utilize my insurance benefits in the future, I agree to deliver written notice of my request to my provider that will take in effect on the date that my notice is signed.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREED TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____

**Printed Name of Client (or guardian if minor)**

_____ _____/_____/_____

**Signature of Client (or parent/legal guardian if minor)** **Date**

**John Cutrone, LMHC, MCAP, A-CAS**

**Printed Name of Witness**

_____ _____/_____/_____

**Signature of Witness** **Date**