

**AUTHORIZATION FOR PAYMENT OF BENEFITS AND  
CLIENT CONSENT**

Date: \_\_\_\_\_  
Federal Tax ID#: 41-1600487

Name of Insured (Print): \_\_\_\_\_

Name of Client: \_\_\_\_\_

I request and authorize that payment of insurance, Medicaid or Medicare benefits be made on my behalf to Caregivers Network, Inc. for home health care services rendered to me or my dependents. I understand that I am financially responsible to Caregivers Network, Inc. for any charges not covered by health care benefits. It is also my responsibility to notify Caregivers Network, Inc. of any changes to my health care coverage.

Insured Address: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Employer: \_\_\_\_\_

Medicare/Medicaid # \_\_\_\_\_

I consent to and authorize Caregivers Network, Inc. nurses and/or Home Health Aides to treat myself or my dependent children listed above. I understand the provider of care is available to explain the purpose of the treatment, and that I have the right to refuse the recommended treatment. I understand I have the right to revoke this consent, in writing, at any time.

X \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Insured