Insurance Authorization and Billing Information

Date:_____ **Name:**_____

1. PAYMENT OF INSURANCE BENEFITS

I request that payment of authorized Medicare or insurance benefits be made to Providence Recovery Services of Colorado, LLC for any service furnished to me by any authorized provider at Providence Recovery. I authorize any holder of medical information about me to release to CMS (Center for Medicare and Medicaid) and its agents, or my insurance company, any information, written or oral, needed to determine these benefits or the benefits payable for related services.

2. CONCERNING INSURANCE

Patients who carry health care insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. Although our office may accept the type of insurance you have, that does not mean that we are in-network with your insurance company. This may mean that you will have a balance that your insurance does not cover and you will be billed for that amount.

COPAYMENTS are required at the time of visit-this includes any copayment with secondary insurance.

You are responsible for payment of your account.

3. DISCLOSURE OF HEALTH INFORMATION

I understand that my individually identifiable health information may be used and disclosed to carry out treatment. Providence Recovery will provide information to your physical health provider to assist him/her in treating you only if given permission by you, the client, to release this information.

I understand that the Notice of Privacy Practices provides a more complete description of the type of uses and disclosures and that I should review the Notice and acknowledge that I received it before signing this consent form.

I understand that Providence Recovery reserves the right to change the terms of the notice and to apply the revised practices to health information already maintained. Any revision to the Notice will be described in a revised Notice that will be posted prominently in our facility.

I understand that I may request Providence Recovery restrict how my individually identifiable health information is used or disclosed to carry out treatment, payment or health care operations. Providence Recovery is not required to agree to requested restrictions, but if Providence agrees to a requested restriction, the restriction is binding.

I understand that I may revoke the consent at any time by notifying the Providence Recovery in writing, except to the extent that Providence Recovery has taken action in reliance on the consent.

I understand that I do not have the right to revoke the authorization if it was obtained as a condition of obtaining insurance coverage another application law provides the insurer that obtained the authorization with the right to contest a claim under the policy. If I choose to revoke the authorization, I understand that I may be denied treatment or eligibility for benefits. I also understand that revocation will not apply to information that has already been released in response to this authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations.

I acknowledge that I have read the above and understand and consent to all sections.

Signature of client or legal representative Date