ASSIGNMENT OF BENEFITS

Patient Name: _____ ***Patient Number:*** _____

I hereby authorize _____ *and their review agencies to make payment directly to Conifer Park of medical benefits otherwise payable to me for treatment services rendered by Conifer Park.*

RELEASE OF INFORMATION:

I hereby authorize release of information necessary in the processing of payment for my treatment at Conifer Park. This release shall authorize release of information to my insurance carrier, its utilization review organization, and/or other parties involved in the processing of payment for my treatment.

I understand that I need not consent to release of information in order to obtain services. I choose to do so willingly and voluntarily for the purpose specified above. The duration of this authorization is for this admission and will expire when my account is paid in full. I understand that I may revoke this consent at any time by notifying the Dept. of Health Information Management in writing, except to the extent that action has been taken in reliance on my consent.

FINANCIAL POLICY:

I understand that Conifer Park cannot guarantee information received from insurance verification, and that said verification is no guarantee of payment. I also understand that I am personally responsible for payment of any balance. I understand that I will receive a refund for any balance not used because of early discharge or insurance payment. There will be a $25.00 return check fee on returned checks.

I have been advised that all physician's fees for psychiatric services are billed to the insurer separately and are not included in hospital stay costs unless described as such in a service contract or provider agreement with that insurer. The insurer may receive additional itemized billing for such ancillary services as clinical laboratory studies, electrocardiogram(s), psychological testing, pharmacy services unrelated to chemical dependency treatment at Conifer Park. Under some circumstances, professional services for individual, group and/or family therapy, tutorial services may be itemized and billed separately.

I have also been informed that consultative and treatment services for medical care (i.e. applicable dental, neurology, anesthesiology, radiology, internal medicine, pathology services, ambulance services) are provided via arrangement with private practitioners and/or other hospitals and that the preceding are private contractors and are not employees of the hospital/facility. I understand that if the treating physician deems such medical consultation necessary, the patient/sponsor hereby accepts responsibility for payment of the consulting physician's fees.

Signature of Insured:	*Print Name:*	*Date*
Signature of Patient:	*Print Name:*	*Date*

Signature of Parent or Guardian:	*Print Name:*	*Date*
Signature of Witness:	*Print Name:*	*Date*

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further discloser of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute an alcohol or drug abuse patient.

AM-20 Rev. 02/08, 02/10 ***Consent expires when account is zero balance.***