Polara Health

Guiding your way to wellness since 1966

Windhaven Psychiatric Hospital, West Yavapai Primary Care
HIM Dept. 642 Dameron Dr. Prescott, AZ 86301
Phone: (928) 445-5211 ext. 4007 Fax: (928) 717-1204

Financial Consent

I understand that services rendered to me by Polara Health., West Yavapai Primary Care, CSU, and Windhaven Psychiatric Hospital (individually and collectively "Provider") are my financial responsibility and that the Provider will bill my insurance company as a courtesy.

I authorize my insurance company to pay my benefits directly to Polara Health and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the Provider and I have agreed to promptly pay any balance of professional service changes over and above the insurance payment.

Due to policy provisions in your contract with your insurance carrier we are obligated to collect all patient responsibility balances.

If your insurance policy has provisions such as deductibles, co-insurances, or co-payments please note that these are provisions that have been agreed to between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier.

If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier. If a portion of your fees are applied to an annual out of pocket maximum, and we do not collect that fee, your out of pocket maximum has not been correctly calculated.

Additionally, for those Medicare patients that may have any medical services that are eligible under Medicare, we are legally obligated to collect the patient responsibility co-insurance, co-payment or deductible under the terms of the anti-kickback laws.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state and federal prompt payment guidelines. I will provide all relevant and accurate information to facility the prompt payment of the claim by my insurance company. Polara Health accepts payment in cash, by credit card, check or other certified funds. If needed, payment arrangements can be negotiated by contacting the Billing Department at 928-445-5211 ext. 4099.

I also understand that should my insurance company send payment to me, I will forward the payment to Polara health within 48 hours. I agree that if I fail to send the payments to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event that I receive any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to Provider. Any violations of this agreement will, at Provider's election, terminate patient charge privileges with Provider and bring any balance owed by patient to Polara Health immediately due and payable.

I authorize the Provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

I authorize Provider to bill my health insurance plan(s): ____

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I authorize the Provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I understand that my substance use disorder records (if applicable) are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless

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otherwise provided for by the regulations. Information released may also include information regulated by 42 USC 260dd-2, and information protected by 38 U.S.C. 7332. It also may include confidential information regarding the testing, diagnosis or treatment of HIV/AIDS (as defined in A.R.S. Section 36-661), sexually transmitted diseases (as defined in A.R.S. section 36-661), or mental/psychiatric illness and for patient at 13-17, information regarding reproductive care.

I understand that I may revoke the authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows: ____

I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

By signing below I give my specific authorization for this information to be bill to my insurance company and if my insurance company requests my medical records to support the claim I authorize the release of records necessary to pay the claim(s).

Provider is hereby released from any and all legal liability that may arise from the disclosure of the information requested. I certify that this request for disclosure has been made freely and voluntarily. I understand that the Provider will not condition treatment on my signing this authorization. The Provider will not deny me treatment if I do not wish to sign this form. However, I assume full responsibility for the charges since absence of my signature does not allow Provider to bill my insurance.

By signing this form I authorize Polara Health to bill my insurance for all Substance Use Disorder Treatment (if applicable). I understand that I can revoke my consent to disclose information from my substance use disorder treatment at any time by contacting the billing department at 3343 N. Windsong Dr., Prescott Valley, AZ 86314 or by calling 928-445-5211 ext. 4099, except to the extent Provider has already acted in reliance on my consent. I understand that the Provider acting in reliance includes the Provider treating me in reliance on my consent to disclose my information to my health insurance plan.

I have read all of the information provided on this sheet. I will notify Polara Health of any changes in my insurance status.

Effective Date of Consent: ____

Client/Patient Name ____ Date of Birth ____________________

Client or Representative Signature: ____

Name (please print) ____ Date ____________________ Phone __________________

Relationship to Client/Patient ____