WEST YAVAPAI GUIDANCE CLINIC

Financial Responsibility

Client/Patient Name: _____

I understand that services rendered to me by West Yavapai Guidance Clinic, Inc, 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 West Yavapai Guidance Clinic, Inc. 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 charges over and above the insurance payment.

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 facilitate the prompt payment of the claim by my insurance company. West Yavapai Guidance Clinic, Inc. 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 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.

Information released may include information regulated by 42 USC 290dd-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), substance use disorder (as defined in 42 CFR section 2.1 et seq.) or mental/psychiatric illness and for patients age 13-17, information regarding reproductive care. 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.

I also understand that should my insurance company send payment to me, I will forward the payment to West Yavapai Guidance Clinic, Inc. within 48 hours. I agree that if I fail to send the payment 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 West Yavapai Guidance Clinic, Inc. 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).

- ☐ AHCCCS and all its subcontracted health plans
- ☐ Blue Cross Blue Shield
- ☐ Medicare and Medicare Replacement Plans
- ☐ United Healthcare
- ☐ Other _____

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Client/Patient Name: _____

By signing this form I authorize West Yavapai Guidance Clinic 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 you of any changes in my insurance status.

Printed Name: _____ Date: _____

Signed: _____

Relationship to Client/Patient: _____

This Authorization expires when payment for all of my services has been received by Provider.