West Patient

Yavapai Guidance Clinic
Financial Responsibility

Client Name
Address _____
City, State, Zip
Phone # _____

Date
Client ID _____
Avatar ID

I, _____**,** understand that services rendered to me by West Yavapai Guidance Clinic, Inc, West Yavapai Primary Care, CSU, and Windhaven Psychiatric Hospital 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 above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this 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 or 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 payments 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.

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

Client/Guardian Signature

Date Signed

Printed Name, if not the client

Relationship to Client