

## *Inspirations for Youth and Families, LLC.*

Client Name: \_\_\_\_\_ MR#: \_\_\_\_\_

### **Assignment of Benefits / Release of Medical Information**

I hereby authorize and request that payment of benefits by my Insurance Company(s) \_\_\_\_\_, be made directly to Inspirations for Youth and Families, LLC., herein referred to as "**Facility**", for services furnished to me or my dependent. I understand that my Insurance Company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment.

In addition, I authorize facility to disclose any and all written information from the above named to my above named Insurance Company and/or its designated representatives, or other financially responsible party, at the determination of facility. Such disclosure shall be for reimbursement purposes for those services received.

I hereby release facility its officers, agents, employees and any clinician associated with my case, from all liability that may arise as a result of disclosure of information to the above named Insurance Company(s) or their designated representatives.

By signing this Assignment of Benefits and Release of Information, I acknowledge:

- I am aware and understand that this authorization will not be used unless the above-named Insurance Company(s) or their designated representatives request records of information for reimbursement purposes; or seek to take action reference payment for treatment services.
- I agree to participate and assist facility its designated representatives with any appeal process necessary to collect payment for the services rendered.
- I am aware and have been advised of the provisions of Federal and State Statutes, rules and regulations that provide for my right to confidentiality of these records.
- I understand that this assignment and authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereof. In any event, this authorization will expire once reimbursement for services rendered is complete.
- Facility is acting in filing for insurance benefits assigned to facility and it can assume no responsibility for guaranteeing payment of any charges from the Insurance Company(s).
- Billing may be done by a firm contracted by facility for billing and collection purposes.
- Facility has been appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier.
- Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.
- Facility shall be entitled to the full amount of its charges without offset.
- I agree to endorse and forward to facility any monies from the Insurance Company paid to me and/or the primary insured. I understand that I am otherwise responsible for the cost of any and all charges accrued.

I acknowledge receipt of a completed and signed copy of this assignment and release form:

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
 Legal Guardian or  Insured Policyholder

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date of Signatures