Allied Behavioral Health Services, Incorporated

Consent to Release Information for treatment, payment, and healthcare operations

I, _____ (Please Print Your Name), Social Security Number _____ hereby authorize Allied Behavioral Health Services, Incorporated and the clinician(s) responsible for my care, at their discretion, to disclose any information including copies of my medical or behavioral health record and/or Private Health Information concerning any treatment to professionals involved with my care or follow-up care; any and all review organizations employed by my insurance carrier and/or third party payor which may be liable for all or part of the medical or behavioral health care charges or who may be responsible for determining the necessity, appropriateness, amount or other matters related to the medical or behavioral health care charges for the care provided; and to Allied Behavioral Health Services, Incorporated committees for Peer Review or Quality Assurance activities and billing and/or administrative consultants. This authorization includes the release of medical or behavioral health records and/or information concerning drug abuse or drug related conditions, alcohol dependence or abuse, psychological and psychiatric conditions, and communicable diseases. I hereby authorize Allied Behavioral Health Services, Incorporated to disclose and release any and all pertinent billing information to any organization responsible for services or any other clinicians providing service(s) to me or my dependent or on behalf of my or my dependent's care. I hereby authorize Allied Behavioral Health Services, Incorporated and clinician(s) to disclose and release any and/or all information, including copies of my treatment record to my insurance carrier or other third party payor if necessary to receive reimbursement for my or my dependent's care.

If the patient is a minor/dependent, I, _____, the parent/guardian consent to the use of the above child's/dependent's social security number for the purposes of patient identification.

Guarantee of Account

In consideration of services rendered to the above mentioned patient/client, I guarantee payment to Allied Behavioral Health Services, Incorporated for all charges incurred on behalf of the named patient/client, including, but not limited to, any portion not authorized, approved, or paid by any insurance organization, Medicare or Medicaid where applicable. **Many insurance carriers have very specific and explicit rules for receiving medical or behavioral health treatment in order for the services rendered to be paid by that carrier. These rules may include: identifying a Primary Care Physician; receiving prior authorization from their Primary Care Physician before having an office visit with a specialist, or getting pre approval from your insurance carrier prior to having an office visit.** Failure to comply with these rules may result in the patient/client or guarantor being responsible for full payment of any outstanding balance.

Assignment of Insurance Benefits

I hereby assign payment of treatment benefits directly to Allied Behavioral Health Services, Incorporated herein specified and otherwise payable to me but not to exceed the agency's regular charges for this period of treatment. This assignment also applies to attending and consulting providers. I understand I am financially responsible for charges not covered by the assignment. This assignment covers all insurance claims, including Medicare, Medicaid and other third parties, filed by the agency and provider for this admission.

I have a right to revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by Allied Behavioral Health Services, Incorporated 22540 Lorain Road, Fairview Park, Ohio 44126. Without my expressed written revocation this authorization will automatically expire upon satisfaction of the need for disclosure.

I acknowledge that the treatment for which I give this consent has been fully explained to me and I have read and fully understand this authorization as it applies to me and/or my dependent.

_____

Patient/Client/Guardian Name (Print)

_____ _____

Patient/Client/Guardian Signature Date