Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Date of Birth \_\_\_\_­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_

I hereby authorize & request that payment of benefits by my insurance company or companies, recorded in my (EClinicalWorks), be made directly to **(Comprehensive Care Providers LLC**), for services provided to me or my dependent(s). I understand that my insurer may only cover a portion of the total bill, based on my coverages. I further understand that I may be responsible for all charges not covered by this assignment of benefits.

In addition, I authorize (Comprehensive Care Providers LLC) to disclose any and all written information from my named insurer and/or its representatives, at the determination of insurer or (Comprehensive Care Providers); such disclosure shall be for reimbursement purposes for services my dependent or I received.

I hereby release (Comprehensive Care Providers), its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the previously named insurance company(ies) or their designated representatives.

By electronically signing this assignment of benefits & release of information, BELOW THIS BOX, I acknowledge:

1. I am aware & understand that this authorization will not be used unless the identified insurance company or its designated representatives request records of information for reimbursement purposes, or seek to take action in reference to payment for evaluation/treatment services.
2. I agree to participate & assist (Comprehensive Care Providers LLC) or its designated representatives with any appeal process necessary to collect payments for services rendered.
3. I am aware & have been advised of the provisions of the Federal & State Statutes, rules & regulations & provide for my right to confidentiality of these records.
4. I understand that is assignment & 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 of services rendered is complete.
5. (Comprehensive Care Providers LLC) is acting in filing for insurance benefits assigned to me, the patient/insured/dependent, and it can assume no responsibility for guaranteeing payment of any charges from the insurance company.
6. A firm contracted by (Comprehensive Care Providers LLC) for billing & collection purposes may perform billing tasks.
7. (Comprehensive Care Providers) is 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. This appointment may include receiving a copy of my insurer’s plan documents.
8. Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.
9. (Comprehensive Care Providers) shall be entitled to the full amount of its charges made, without offset.
10. I acknowledge that this document is electronically connected to MY medical record as entered into the charting system associated with (Comprehensive Care Providers), and that the record attached is mine or my dependent’s.

***By typing or signing my FULL name below, I acknowledge that I have received and read a copy of this from (***Comprehensive Care Providers***).***

Sign\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT full name BELOW:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_