Barrett Clinic

8074 South 84th Street
La Vista, NE 68128

PATIENT AUTHORIZATION FOR THE RELEASE OF BILLING INFORMATION

Patient or patient representative should review the following disclosure carefully regarding the release of Protected Health Information (PHI) for insurance billing purposes.

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I. Our office follows HIPPA regulations in regards to protecting your health care information. As such, we must have each patient's written consent to release (PHI) to any outside agency. Our office uses an outside billing agency to file our insurance claims. If you would like us to file your insurance for services provided, we must release your demographic and insurance information to our billing agency in order to do this. Our billing agency is also bound by the same HIPPA regulations and will release only the minimal information required by your insurance carrier(s) in order for your claim(s) to be processed. If this is acceptable to you, please sign below indicating that you understand this disclosure.

II. Payment for patient's cost share (co-payment, coinsurance and deductible amounts) is normally due at the time of service unless other arrangements are made. If a balance remains after your insurance(s) processes your claim, you may receive a bill from our billing agency. This balance is payable upon receipt of your bill. If your balance remains after your insurance(s) processes your claim, you may receive a bill from our billing agency. This balance is payable upon receipt of your bill. If your balance becomes delinquent (over 180 days old from your last visit), our office may pursue outside intervention in order to collect any monies owed to us. To prevent this from occurring it is important that you contact our office if you have questions regarding your balance. **If your account becomes delinquent and unaddressed, our office would release the minimal information required in order to secure payment. Please sign below indicating that you understand this disclosure.**

Assignment of Benefits

I request that payment of authorized Medicare, Medicaid, Private insurance benefits be made to Barrett Clinic, P.C. for any covered services furnished by Barrett Clinic, P.C. I agree to pay to Barrett Clinic, P.C. the deductible and/or coinsurance on my claim.

I further certify that the information provided by me is true, accurate and complete. I understand and agree that I am responsible for the following expenses; any service my insurance plan deems "not covered," all co insurance and/ or co-payment amounts, all deductibles, any amount that exceeds benefit limits under my insurance plan and any amount my insurance plan deems not covered because I was not insured on the date of services

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Patient printed Name | Patient or responsible party Signature | Date

If responsible party, please complete below:

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Responsible party name | Relationship to patient