Authorization to Bill Health Insurance

Please sign and initial where indicated and return to Kari Apple by e-mail at Kari@HopeTN.com, by fax at 615-346-9278, or by mail at 6369 S Old Hammer Way, Aurora, CO 80016.

I,_____(print name), do hereby give full permission for Hope Autism and Behavioral Health Services to release medical information and to bill_____(name of insurance company) for services rendered to_____(child's name) by Hope Autism and Behavioral Health Services, LLC. I authorize payment of medical benefits to Hope Autism and Behavioral Health Services, LLC for services.

_____I understand that I am responsible for understanding information about my health insurance policy and providing that information to Hope Autism and Behavioral Health Services.

_____I understand that I am ultimately responsible for payment for services rendered by Hope Autism and Behavioral Health Services and agree to pay for the services in full in the case that my insurance company will not cover some or all of Hope Autism and Behavioral Health Services' charges.

_____I understand that no show/late cancellation/travel fees will NOT be billed to my insurance company and that I am responsible for paying these fees if they are incurred.

_____I understand that fees billed to insurance companies are negotiated between Hope Autism and Behavioral Health Services, LLC and the individual insurance companies and may not be the same as fees billed to private-pay clients. I am aware that insurance company rates may change without notice.

_____I understand that if I am late for scheduled appointments, I will be charged for the time the consultant or therapist is waiting and that Hope Autism and Behavioral Health Services will only bill my insurance company for actual service time.

Child's Name _____

Parent/Guardian's Name_____ Date _____

Signature _____

HOPE autism and behavioral health services, LLC

Insurance Information

Insured's ID Number:

Insured's Name:

Insured's Address:

City, State, Zip:

Phone Number:

Insured's Group Number:

Insured's Date of Birth:

Employer's Name: Insurance

Plan Name:

Is there another Health Benefit Plan?

If yes, Plan Name:

Patient's Name:

Patient's Birth Date:

Patient's Address (if different from Insured's):

Claim Address and Provider Phone Number (usually found on back of insurance card):