Client Name: ________________________________ Client ID: _______________

cmmhc
Central Minnesota Mental Health Center
Together, Creating a Healthier Life

Billing Payer Release

1. I authorize Central Minnesota Mental Health Center (CMMHC) to release all Mental Health and/ or CD information electronically, on paper, or orally to my third party payor(s) (e.g. Medical Assistance, county of financial responsibility, insurance company, designated care management organization, Prior Authorization, etc.), requested medical record information, diagnosis, intake assessment, treatment plan/progress notes, dates, type, and provider of service regarding myself and/or my dependents for purposes of processing a claim.
2. I hereby authorize, from this day forward, any insurance company to whom I subscribe to pay directly to CMMHC for services rendered to me and/or my dependents.
3. **I accept full responsibility for notifying CMMHC immediately of any changes in my insurance coverage while receiving care. Failure to do so on my part will result in me being fully responsible for the bill because insurance will not cover without pre-certification notification. I also understand that insurance coverage cannot be determined until after claims processing and that non-covered services/providers will be my financial responsibility.**

I also authorize CMMHC to discuss my billing records with the following people:

- Spouse: __________________________ Parent/ Guardian: ________________________________
- Other: __________________________ Specify relationship: ________________________________

____ ________________________

Signature of Client, Parent, or Legal Guardian Date

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______________________________________INSURANCE WAIVER/PAYMENT FOR PROGRAM SERVICES

(Insurance Company)

I am requesting the following service/procedure: ____

I have been advised that receiving the above noted services at CMMHC likely will or has already been determined to be medically unnecessary for insurance reimbursement and agree to be financially liable for my portion of the cost of the services.

____ ________________________

Signature of Client, Parent, or Legal Guardian Date