Client Name: _____ Client ID: _____

Billing Payer Release

1. I authorize Central Minnesota Mental Health Center (CMMHC) to release all Mental Health and/ or Substance Use Disorder (SUD) information electronically, on paper, or orally to my third party payer(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.

4. I understand that if I cannot pay my balance in full, I am able to set up payment arrangements. I also understand that I may be eligible to apply for a reduced rate through Sliding Fee Scale (income limits may apply). Sliding Fee Application needs to be completed prior to the service and required documents/ verification of gross income is required within 30 days of application.

Please check one of the following:

☐ I acknowledge that I am responsible for all charges not paid by my insurance plan, for services provided to me or any other individual that I serve as the guarantor/ responsible party.

☐ I have been advised that receiving 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

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

- Spouse: _____ Parent/ Guardian: _____
- Other: _____ Specify relationship: _____