RURAL PSYCHIATRY
ASSOCIATES

CONSENT FOR RELEASE OF PRIVATE INFORMATION TO INSURANCE COMPANY AND ASSIGNMENT OF BENEFITS

I hereby authorize Peterson Medical Clinics, LLC dba Rural Psychiatry Associates to disclose to my insurance carrier(s), present and past information required to prepare an insurance claim. The insurance company will use this information to process my claim for benefits.

I authorize Peterson Medical Clinics, LLC dba Rural Psychiatry Associates and/or their assigned billing company to submit claims, on my and/or dependent's behalf, for payment to Medicare, Medicaid or any other payer for services provided to me or my dependent. I assign the right to appeal payment denial or other adverse decisions made by my benefit plan to Peterson Medical Clinics, LLC dba Rural Psychiatry Associates and/or their assigned billing company on my behalf.

I authorize all insurance payable on claims originating from Peterson Medical Clinics, LLC dba Rural Psychiatry Associates to be paid directly to Peterson Medical Clinics, LLC dba Rural Psychiatry Associates and/or their assigned billing company. I understand that I am financially responsible for the billed charges for these services regardless of my insurance coverage and in some cases may be responsible for all charges not covered by this assignment, such as co-pay, co-insurance, deductible and any remaining balance.

I understand that no other use will be made of this information except for that otherwise authorized by law.

_____
Patient's Name (Printed)

_____ _____
Patient's Signature Date

_____ _____
Parent/Legal Guardian's Signature Date

*By signing your name electronically, you are agreeing that your electronic signature is the legal equivalent of your manual signature.