Phoenix Group Home, LLC dba Path Behavioral Healthcare dba Path Integrated Healthcare

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY (PRIVATE PAY & COMMERCIAL INSURANCE ONLY)

CLIENT INFORMATION:

Client Last name	Client First name	Client DOB
Address		Client SSN
Name of Insurance Company/Plan		Policy#

RELEASE OF INFORMATION: I authorize Phoenix Group Home, LLC dba Path Behavioral Healthcare dba Path Integrated Healthcare ("PATH") to disclose and release to my insurance carrier(s) any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize PATH to act as my agent in helping obtain payment from my insurance companies.

INSURANCES WE TAKE: PATH accepts only established private pay, commercial insurance with Out-of-Network with mental health and / or substance benefits, and Medicaid. **We accept very select In-Network Commercial insurance.**

CO-PAYS AND DEDUCTABLES: We have verified your out-of-network insurance coverage and educated you about estimated coverage, co-pays, and deductibles. You are responsible for paying all co-pays and deductibles at the time of service if you have out-of-network insurance.

GUARANTEES: PATH does not guarantee that your out of network insurance company will pay for treatment you receive from our practice. If you lose your insurance, you must notify us immediately. In the event that your insurance is lost or your insurance claim is denied, you will be responsible for paying the full amount of the fee.

OUT OF NETWORK CHECKS: Out of network insurance companies may mail a check or checks to you to cover our fees. You must mail or drop off the check at your local PATH office within 5 days of receipt. If you cashed the check, you must mail or drop off a money order or cashier's check made out to PATH in the same amount. Failure to sign over and deliver to PATH will result in 1) termination of services; 2) the bill being sent to a collection agency; and 3) the amount of the check being reported to the Internal Revenue Service as taxable unearned income.

ASSIGNMENT OF OUT OF NETWORK BENEFITS: I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my out of network insurance plan(s) directly to PATH for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation.

LABORATORY SERVICES: Generally, most laboratory specimens are sent to an outside laboratory. The laboratory will bill you separately for their services.

DECLARATIONS: By signing below, I understand that I am financially responsible for charges if I private pay or a charge is not covered by my out-of-network insurance company. I also agree to pay any collection and attorney fees to PATH if this matter is referred to collection.

Policy Holder' Signature*	Date
Printed Insurance Policy Holder's Name	Relationship to Patient

(PATH STAFF ONLY) Client EHR ID #: _____

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INFORMED CONSENT (ALL CLIENTS)

Client Last name **Client First name** **Client DOB**

CONSENT FOR TREATMENT: The rates, policies, regulations, services, and statutory provision concerning client rights have been explained to me. I understand that, as an individual, I shall receive appropriate evaluation and treatment by PATH. I understand my consent is ongoing until revoked by written notice.

The attendant benefits and risks of treatment have been explained to me. I agree and consent to treatment by PATH. I give my permission for PATH to seek emergency medical care, if necessary, from the nearest Hospital or Physician.

RELEASE OF INFORMATION TO BILL FOR SERVICES: I authorize PATH to disclose and release to my insurance carrier(s) any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize PATH to act as my agent in helping obtain payment from my insurance companies.

ACKNOWLEDGEMENT OF PROVIDER CHOICE: I acknowledge that I have been educated about the choices of provider agencies that offer the services I am eligible for, and I have freely chosen PATH without duress or coercion.

ACKNOWLEDGEMENT OF ORIENTATION TO SERVICES: I acknowledge that I have been oriented to the services. I acknowledge that I have received PATH's Client Handbook that includes but is not limited to your rights, our grievance procedures, and a privacy statement and have had the opportunity to ask questions. **Client Documents:** https://pathihc.com/consents-clients-rights/

REMINDER CALLS: I agree to receive calls or text messages from PATH to remind me of appointments.

ASSIGNMENT OF MEDICAID BENEFITS: I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under Medicaid directly to PATH for services rendered. If you lose your Medicaid insurance, you must notify us immediately. I acknowledge that, in the event of a loss of Medicaid coverage, I will be responsible for the full amount of PATH's fees.

TELEHEALTH CONSENT: I consent to participate in telehealth treatment. I understand that telehealth is the practice of delivering healthcare services via electronic means between a practitioner and a client who are located in two different locations. I understand the following:

1. I have the right to withdraw this consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

This service is provided by technology and may be via text, audio only telephone, or 2-way interactive video. There are benefits and limitations to this service. I will need access to, and familiarity with, the appropriate technology to participate in the service provided.

I understand that there are risks, benefits, and consequences associated with telehealth including but not limited to: disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies. I understand it is my responsibility to ensure privacy on my end of the communication.

2. I understand that there will be no recording of any of the online sessions by either party. Privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; etc.).
3. I understand that if my provider determines that telehealth services are not an effective treatment modality for any reason, I will be referred to the applicable level of in-person care that is indicated.
4. I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, I will immediately call my provider by phone to be reconnected and resume the session. If I am unable to reconnect immediately, the appointment will need to be rescheduled.
5. I acknowledge that I have received training in the Features, Setup, Use, and Troubleshooting of the telehealth platform.

I, the undersigned, agree to and acknowledge that I have been educated about the above.

Patient or Legally Authorized Representative's Signature _____ Date _____ Relationship to Patient _____

Patient or Legally Authorized Representative Printed _____

(PATH STAFF ONLY) Client EHR ID #: _____

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