Employee Assistance

Behavioral Health Programs

& ASSOCIATES, INC.

RESPONSIBILITIES FOR INSURANCE CLIENTS

IN CONSIDERATION OF THE SERVICES PROVIDED, I, THE UNDERSIGNED, AGREE AS FOLLOWS:

AUTHORIZATION FOR SERVICES: Many insurance companies require prior authorization of services which must be obtained by the client. I understand that the provider of services utilizes a billing service, Clear Solutions, LLC, to manage insurance eligibility, verification, authorization, billing, and/or collections. **I understand that verification of benefits is not a guarantee of payment and claims will be processed according to my insurance plan at the time services are rendered.** While Clear Solutions, LLC will contact my insurance company to determine benefit and authorization information, I understand that I still must contact my insurance company in order to obtain any authorization that is needed. By signing below I agree that I have already contacted my insurance plan to determine if an initial authorization for services is required and obtained such authorization or that I will contact my insurance plan immediately to determine if an initial authorization for services is required and obtain such authorization. I understand if prior authorization is required and I fail to obtain such authorization (whether the provider is contracted with my insurance plan or not) I will be liable for services in full.

I agree to inform Clear Solutions, LLC and/or my provider of service immediately of any changes in insurance. If claims are denied due to insurance changes, I understand that I am responsible for all charges.

I hereby appoint and authorize Clear Solutions, LLC to represent me in demanding, collecting, and receiving all sums of money due and payable to me with respect to any insurance, medical reimbursement, benefits, disability plans, contract or policy arising directly or indirectly as a result of services provided to me or my dependent(s). I authorize the release of any medical or other information necessary to process the claim.

In the event my account is placed for collection, I agree to pay all costs for collecting the balance due in addition to any outstanding balances including but not limited to attorney or collection agency fees.

Printed Name of Patient _____ Date _____

Signature of Patient/Guarantor/Guardian _____ Date _____

Signature of Provider _____ Date _____

Fill out this form electronically or by hand and EMAIL to drgup@gupinc.com