# Responsibility For Account - Assignment of Benefits - Billing Insurance

Client Name: _____ DOB: _____

## Client Agreement, Authorization, Consent and Release

1. It is agreed that my insurance is to be billed for all services provided by Minnesota Psychological Resources (MPR) as long as my insurance is in effect and the insurance limits have not been exceeded. I understand that I will pay the deductible, co-pay and/or co-insurance required by my insurance company. It is also agreed that I will make the payments at the time of the therapy session.
2. I authorize MPR to send my bills for my medical care and treatment to my insurance company, other payor, and/or Medicare or Medicade for payment, to the extent my insurance company, other payor, and/or Medicare or Medicade is required to pay the bill under the terms of my insurance policy or by law.
3. I request that my insurance company, other payor, and/or Medicare or Medicade pay MPR for the services provided in my treatment.
4. I consent to the release of my medical record by MPR to my insurance company, other payor, and/or Medicare or Medicade (and organizations working on their behalf) if necessary in order for my bills to be paid.
5. I agree to pay for any charges not covered by my insurance.
6. I understand that MPR will charge interest on unpaid balances 30 days after the date of service and I accept responsibility to pay interest charges.
7. I understand that the information my insurance company provides to me or MPR is NOT A GUARANTEE of the benefits provided or paid by my insurance company. Therefore, I accept full responsibility for all charges for services provided by MPR.
8. I understand that psychological testing fees involve an additional charge and are not included in the charge for the therapy sessions.
9. I understand that in the event that MPR has been unable to collect payment for services, MPR has the right and will turn my account over to a collection agency.
10. I understand that there is a $20 charge for NSF checks or any other checks that are returned to MPR.

### Release of Records for Mental Health Care as Required by Law:

_____ INITIAL TO INDICATE UNDERSTANDING: a copy of my records may be sent

- To health care providers directly involved with my care.
- To State, Federal and accrediting bodies for required reporting and/or surveys for compliance.

**NOTE: Records are not automatically sent to your referring physician. They must be requested.**

I authorize payment of medical benefits to Minnesota Psychological Resources (MPR). I recognize MPR cannot guarantee payment of charges by any particular insurance company and I am ultimately responsible for the entire bill including deductibles and co-payments. When applicable, I also request payment of government benefits to MPR, which accepts assignment.

By signing this form, I consent to authorize my medical or mental health provider to assess and treat me. I understand that my provider is available to explain the purpose of the treatment, and that I have the right to refuse the recommended treatment. I understand I have the right to revoke this consent, in writing, at any time except where MPR has already made disclosures in reliance on this consent.

_____ _____

Client Signature (If a minor, Parent/Guardian's signature)

_____ _____

MPR Representative Signature Date