rosecrance

ROSECRANCE AND AFFILIATES
Assignment of Benefits / Guarantee of Payment

Client Name: _____ Client ID: _____ Client DOB:_____

Financial Responsibility

I acknowledge and agree:

- That I am financially responsible for all charges for services provided.
- That some or all of the services provided to the client by Rosecrance may not be covered by insurance.
- That I am responsible for all charges for services provided to the client listed above which are not covered by insurance or that are required under my Insurance Plan, such as co-payments or deductibles.
- That Rosecrance may be in-network or out-of-network and I will be responsible for additional charges not covered by policy.
- That this financial form with assignment of benefits applies and extends to subsequent visits and appointments at Rosecrance.
- That Rosecrance will verify benefits prior to starting treatment and will share the information with me, but this does not guarantee payment. My insurance company's failure to process claims according to the verification of benefits information provided does not indicate an error by Rosecrance.
- That misrepresentation of insurance information may make me legally responsible for payment to Rosecrance.
- That I am responsible for keeping my insurance information up to date.

_____ _____

Name of Financially Responsible Person Signature of Financially Responsible Person Date

Assignment of Benefits

In exchange for and consideration of services provided by Rosecrance to the client listed above and to provide timely and accurate payment for such services:

- I certify that the information given by me for purposes of payment for the client's treatment at Rosecrance is, to the best of my knowledge, **complete and accurate and that no other coverage or insurance exists**.
- I assign my right to receive payment of authorized benefits to Rosecrance.
- I also assign and convey to Rosecrance all rights, powers, authority, and standing to pursue amounts owed under my health insurance plan and to pursue vindication of my rights under my health insurance plan or federal or state law incurred as a result of the treatment I receive from Rosecrance (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal or administrative claims.
- I authorize Rosecrance to file an appeal on my behalf for any denial of payment or adverse benefit determination.
- If my Insurance Plan will not direct payment to Rosecrance, I agree to endorse and forward to Rosecrance all health insurance payments, which I receive for the services rendered by Rosecrance and its health care providers and I agree that I am personally liable to Rosecrance for such monies.
- I understand that Rosecrance would not have accepted the undersigned as a patient, except for this assignment and guarantee of payment.
- If my current health insurance plan prohibits assignment of benefits, I hereby instruct my plan to provide documentation demonstrating such non-assignability to myself and Rosecrance. Failure to provide such documentation within thirty days of receipt of the claim submission shall constitute consent to and assignment and/or knowing and intentional waiver of any non-assignability clause by the plan. Acceptance of a claim submission from Rosecrance, or issuance directly to Rosecrance of an explanation of benefits, remittance advice, determination letter, or other decisional communication concerning the claim, shall be deemed to be consent to assignment or waiver of any non-assignability clause by the plan, its fiduciaries, and/or its third-party administrators.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I intend by this assignment and designation of authorized representative to convey to Rosecrance all my rights to claim the benefits related to services provided by Rosecrance, including rights to any settlement, insurance, or applicable legal or administrative remedies (including claims brought pursuant to state law, federal law or the provisions of ERISA, whether such claims seek benefits, statutory penalties, or prospective, retrospective, monetary, legal, equitable, or other relief, including without limitation claims for breach of fiduciary duty or claims related to the Mental Health Parity and Addiction Equity Act of 2008 ("Parity Act") or any state law

equivalent of the Parity Act). Rosecrance is given the right by me (1) to obtain information regarding the claim to the same extent as me including the summary plan description, certificate of coverage, or other document setting forth the terms of the plan or under which the plan is operated; (2) to submit evidence; (3) to make statements about facts or law; (4) to make any request, including providing or receiving notice of appeal proceedings; (5) to participate in any administrative and judicial actions and to pursue claims or actions against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. As my assignee and my designated authorized representative, Rosecrance may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense. I instruct Rosecrance to use whatever funds may be recovered as a result of actions brought on my behalf to reduce or eliminate any debt I may owe to Rosecrance and any related debt owed by Rosecrance for expenses incurred whilst seeking full reimbursement from my insurer, employer benefit plan, or third-party administrator.

I certify that I have read and understand the above statements, that all of my questions have been answered to my satisfaction, and that I agree with each statement above.

I understand that I have the right to inspect and copy the information to be disclosed. I will be given a copy of this authorization for my records.

_____	_____	
Name of Client/Parent/Guardian	Signature of Client/Parent/Guardian	Date