

**ROSEMARIE STEFANIW-GOTTLIEB, C.N.P.  
ADVANCED BEHAVIORAL HEALTHCARE**

**ASSIGNMENT OF BENEFITS**

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have completed all of the attached information. I certify this information is true and correct to the best of my knowledge. I acknowledge that I am responsible for notifying you of any changes.

I authorize the release of medical information and benefits to be paid directly to Primary Care & Psychiatric Services, Inc. d/b/a Advanced Behavioral Healthcare.

\_\_\_\_\_  
**Signature of insured**

\_\_\_\_\_  
**Date**

**RELEASE OF INFORMATION**

I authorize Primary Care & Psychiatric Services, Inc. or the billing service to release any of the following information for the purpose of obtaining reimbursement/payment for treatment services provided to my dependent or me. The Information may include the diagnosis, designated clinical records, and/or the procedure code. This information may be released to any third-party payor having responsibility for payment of charges, review agents or managed care/utilization review agents.

This consent is valid until such time that all claims have been settled or up to 1.5 years from the date of discharge.

I understand that In some cases I and/or some of my dependents may be receiving services for which I am not the insured and there is more than one insured. In this case I authorize Primary Care & Psychiatric Services, Inc. to contact the actual or additional insured and to share information necessary to obtain reimbursement for services.

I understand that I can revoke this consent at any time and that I may inspect and copy the information to be disclosed. I can revoke this consent at any time as long as I submit the revocation in writing to Primary Care & Psychiatric Services, Inc.

I understand that I am ultimately responsible for any and all charges not paid by my medical insurance, and if I refuse to sign this release, I will likely have to pay for any and all charges.

I certify that I am the client and that I understand this form. I can receive a copy of this form upon request. If I am not the patient, I certify that I am authorized as the patient's agent to accept these terms.

**Patient's Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_