6155 Oak Street, Suite E
Kansas City, Missouri 64113
Phone: 816-333-0606
Fax: 816-523-5418

Behavioral Health Partners

AUTHORIZATION FOR EVALUATION AND TREATMENT

The resident, legal guardian, or health care surrogate, if any, hereby authorizes **Behavioral Health Partners** to evaluate and treat, if necessary:

_____ at _____.
Resident name *Facility name*

This consent may be withdrawn at any time. Withdrawal of consent must be in writing to Behavioral Health Partners.

The resident, legal guardian, or health care surrogate, if any, has read and has had fully explained to him/her, and fully understands the above Authorization for Evaluation and Treatment. No guarantee or assurance has been made to the resident, legal guardian, or health care surrogate, if any, concerning the results, which may be obtained. I understand that a copy of the HIPAA Disclosure is on file with:

_____, and that I may review this at any time.

ASSIGNMENT OF BENEFITS

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your carrier. As Medicare participating providers, Behavioral Health Partners will accept assignment. According to Medicare guidelines, the providers will always accept the amount of Medicare's allowable, as charge owed by Medicare and Secondary insurance. The patient may be billed for Medicare deductible and co-insurance amounts in the event that there is not a secondary insurance or if the secondary insurance does not pay the Medicare deductible.

MEDICARE

I request the payment of authorized Medicare benefits may be made to Behavioral Health Partners. I authorize any holder of Medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to Behavioral Health Partners any information regarding Medicare claims under the Title XVIII of the Social Security Act.

SUPPLEMENT INSURANCE

I hereby authorize the release of any information listed below that is necessary to file a claim with the insurance company and assign benefits to Behavioral Health Partners.

_____
Signature of resident, legal guardian or health care surrogate *Date*

_____
Printed name of resident, legal guardian or health care surrogate *Date*

PRIMARY INSURANCE

_____
Company name

_____
Street address

_____
City, state, zip

SECONDARY INSURANCE

_____
Company name

_____
Street address

_____
City, state, zip

WHITE COPY: Facility **YELLOW COPY: Behavioral Health Partners**

Rev. 10/05

DO NOT THIN FROM CHART