GLIO Counseling Group

837 S. Lapeer Rd, Ste 205, Oxford MI 48371

Tel. 248-572-7002 Fax 248-572-7016

FINANCIAL RESPONSIBILTY/ASSIGNMENT OF BENEFITS (MICHIGAN)

I understand that I am responsible for paying my co-payments, co-insurance and deductibles at the time of service. I also understand that I am responsible for any balance not covered by my insurance company.

I, the undersigned, understand that GLIO Counseling Group will bill my insurance carrier for services rendered. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for medical care and services rendered. If my insurance company does not remit payments, I understand that I will be responsible for the balance in full.

Pursuant to the assignment of benefits herein; I hereby request that my insurance carrier make payment directly to GLIO Counseling Group for all services rendered by this facility. If my current policy prohibits direct payment to GLIO Counseling Group, I hereby instruct and direct my insurance carrier to make the check out in my name but send the check to GLIO Counseling Group, 837 S. Lapeer Rd., Oxford, MI 48371. If my insurance carrier makes payments to me, I agree to immediately pay over these funds to GLIO Counseling Group. I also authorize GLIO Counseling Group to deposit checks received on my account when made out to me. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collection monies owed., including court costs, collections agency fees and attorney fees.

ASSIGNMENT OF BENEFITS

I hereby assign all mental health/behavioral health and substance abuse treatment benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and other health/medical plan, to issue payment check(s) directly to myself and/or my dependents(s). I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize GLIO Counseling Group to: (1) Release any information necessary to insurance carriers regarding my illness and treatments.; (2) To process insurance claims generating in the course of examination or treatment.; (3) To allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

CANCELLATION POLICY

A $50 fee will be charged for all cancellations and/or No shows unless 24-hour prior notification is made.

Patient Name: _____ SS# __ __ __ - __ __ - __ __ __ __

Signature: _____ Date: _____