skip if you are not using insurance

Renovate Mental

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Germantown, MD 20876
Phone/Fax: 301-828-2350
customerservice@renovatemental.com

Authorization to Bill Insurance

By signing below:

- I understand that **Renovate Mental, LLC** will check my eligibility as a courtesy.
  - It is my ultimate responsibility to ensure that **Renovate Mental, LLC** or any of its providers are in-network with my insurance.
- I understand it is my responsibility to understand my insurance benefits, including any deductibles, co-pays, or co-insurance amounts.
- I certify that I am requesting the services of **Renovate Mental, LLC** for myself or my minor child, for the purposes of mental health evaluation, recommendations, and treatment.
- I certify that I have been advised and have received a copy of my rights to confidentiality. I understand that these rights will be respected and upheld. I understand that disclosure of information suggesting harm or the threat of harm to myself or any other person—by myself or my child—requires notification of the appropriate authorities and/or agencies as mandated by law.
- I request payment of authorized insurance benefits or subsidies made, on my behalf, payable to **Renovate Mental, LLC** for any services provided to me. I authorize any holder to release to my insurance company medical information about me needed to determine benefits or the benefits payable for related services, regulatory compliance, state audit or quality assurance purposes.
- I understand that **Renovate Mental, LLC** will submit my insurance claims ON MY BEHALF, **and that I will be responsible for any deductible, co-payments, co-insurance or any fees that are not covered by my insurance at the time services are rendered**. This includes if there are changes in your insurance plan, or a lapse in coverage.
- I understand that I will receive a monthly statement if my account has a balance due. I understand that **Renovate Mental, LLC** cannot accept responsibility for collection of my insurance claim or for negotiating a settlement on a disputed claim and that I am responsible for payment of my account.
- I understand that there is a 24 hour cancellation policy and if I fail to appear for a scheduled appointment, I will be responsible for applicable no show fees.

If filling out on behalf of another, please state their name here: _____

_____ _____

Client Signature Date

_____ _____

Provider Signature Date