The Shamrock Group, Inc.

DBHR Certified Chemical Dependency Agency
Approval Number: 17 0097 00

Authorization for Release of Information to Insurance Company

NAME: _____
(LAST) (FIRST) (MIDDLE)

FULL ADDRESS:_____

IS BILLING ADDRESS THE SAME: _____ IF NOT PROVIDE BILLING ADDRESS:
_____

PHONE NUMBER: (HOME) _____ (WORK) _____

DATE OF BIRTH: _____/_____/_____ SEX: (MALE) _____ (FEMALE) _____

SOCIAL SECURITY #: _____ WHERE EMPLOYED: _____

OCCUPATION: _____

NAME OF PRIMARY INSURANCE TO BE BILLED: _____

CUSTOMER SERVICE NUMBER ON CARD: _____

GROUP/PLAN NUMBER: _____

POLICY/MEMBER NUMBER: _____

I, _____, Date of Birth: _____authorize The Shamrock Group, Inc. and all business partners to release billing information which may include client name, date and type of services, diagnoses codes, substance abuse treatment information and/or treatment plans to my insurance company for the purpose of: collecting insurance benefits and/or for authorization of additional service/sessions. I understand that my medical records may contain information regarding HIV/AIDS, Substance Abuse, mental health and/or other sensitive material. I also give permission that my insurance directly pay The Shamrock Group, Inc.

Patient Signature: Date:

This information has been disclosed to you from the records protected by Federal confidentiality rule (42 CFR, Part 2). The federal rules prohibit you from making further disclosure of this information without written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR, Part 2. A general release of medical or other information is not sufficient for this purpose. You are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this message in error, please notify us immediately by telephone, and return the original message to The Shamrock Group, Inc. Via the US Postal Service. Thank you.

10564 5th Avenue Northeast * Suite 301* Seattle, Washington 98125
Telephone: (206) 789-4784 * Fax: (206) 789-4786
www.theshamrockgroup.net

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- I understand that I have the right to inspect the information released through this authorization and such an inspection will occur in a meeting with Steven E. Schumann, M.A., CDP and/or my counselor at The Shamrock Group, Inc.
- Any remaining balance that is not covered by your insurance is your responsibility and will need to be paid within 30 days of services rendered.
- I understand that I may revoke this authorization by providing a written revocation.
- I also understand any information released prior to the revocation may be used for the purpose(s) listed above.
- A photocopy of this authorization shall have the same force as the original.
- Returned Checks: There is a fee of $25.00 charge for all returned checks.
- The information may be released in the following format: Written – Verbal - Electronic (including fax)
- This release shall be valid for one year after patient signature date, unless otherwise restricted.

Patient Signed: _____ Date:_____

Witnessed:_____ Date:_____
The Shamrock Group, Inc.

** The Shamrock Group, Inc. will need to photocopy your insurance card at your first session**

Although your insurance provider may cover all your fees, ultimately it is <u>your</u> responsibility to cover all your costs. Some plans require preauthorization before your first visit. It is <u>your</u> responsibility to obtain this authorization. Mental Health benefits may differ from your medical benefits so it is essential that you have researched your mental health benefits prior to your visit. If you have not done this prior to your visit, and/or your treatment is not a payable benefit, you will be responsible for the full cash payment at the time of service. Further, if your insurance carrier determines that the services received are not medically necessary, you will be responsible for full payment of your accrued fees.

Patient Signature: Date:

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