PATIENT:_____

RESPONSIBLE PERSON:_____

RESPONSIBLE PERSON'S RELATIONSHIP TO PATIENT:_____

Insurance Authorization

I acknowledge that ARKANSAS FAMILIES FIRST, LLC (AFF) and its contracted billing company, The Technology Edge, Inc. (TTE), will file insurance claims on my behalf. I authorize assignment of benefits and further give permission for AFF and/or TTE to release information to my insurance company if requested.

_____Signature _____Date

Patient Privacy In compliance with the state and federal requirements of HIPAA I have been provided with a copy or access to AFF's policy and procedures regarding the protection, security, and release of my Protected Health Information.

_____Signature _____Date

Scheduled Appointments

I understand and agree to pay for the cost of appointments that I miss if I have not provided Arkansas Families First with a notice of my intention to cancel within twenty-four (24) hours of the appointment time. I understand that my insurance coverage will not pay and will not be billed for missed appointments.

_____Signature _____Date

Billing and Payment for Services

I agree to pay for services at the time they are provided, unless I have agreed otherwise or unless my insurance coverage requires another arrangement. Further, I understand that AFF and/or TTE staff will contact insurance providers to determine benefits, however, I also understand that neither AFF or TTE can guarantee that the information provided by the insurance provider is accurate. I agree to pay for all agreed to services that **might not be** covered by my insurance plan including non-covered diagnoses or procedures (e.g., testing, group, marital counseling).

_____Signature _____Date