Assignment of Benefits / Guarantee of Payment

For the purpose of obtaining the admission of _______________________ [insert client's name here] ("Client"), DOB: ____/____/____, I authorize and agree to the following disclosures:

Client, or Client's personal representative, authorizes TASC, Inc. to disclose to and/or obtain the Information listed below from the following (hereinafter, together referred to as "Payor Sources"):

- Client's or parent's/guardian's insurance company/employer group: Specify______________________________
- Illinois Department of Human Services (DHS),
- Illinois Department of Healthcare and Family Services (HFS),
- Illinois Department of Children and Family Services (DCFS),
- Managed Care Organization: Specify: ____________________________
- Other third-party payor or funding source, and/or credit card or payment processing entity
  Specify: ____

Client, or Client's personal representative, authorizes the Payor Sources to disclose to and/or obtain from Client, or Client's personal representative, the Information listed below.

INFORMATION TO BE DISCLOSED AND/OR OBTAINED:
Presence/participation in treatment, demographic information, medical information, treatment information/records (assessment, diagnosis, treatment plan, dates of service, type of service and/or level of care received), financial information and any other information that is necessary to fulfill the Purpose and Condition, below.

PURPOSE AND CONDITION
The purpose of this disclosure of information is for TASC to obtain pre-authorization and/or certification for treatment services, determine eligibility, coordinate benefits, submit healthcare claims, obtain reimbursement, or discharge the legal or contractual obligations of the Payor Sources for services provided to Client. If other purpose, please specify: _______________________________________. I understand that treatment is being provided to Client in reliance on obtaining payment for services rendered.

REVOCATION
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the Compliance Administrator at TASC. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

EXPIRATION AND REDISCLOSURE
Unless sooner revoked, this authorization expires one year post discharge, until all claims relating to the client's treatment are filed, processed and paid in full, or no later than ________ (if not otherwise stated, this date shall be

one year from the date of this authorization). State and Federal law prohibit the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 or the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/1 et seq.).

Assignment of Benefits

I authorize and direct that any insurance proceeds payable for services provided by TASC to Client be paid directly to TASC and I hereby assign to TASC all interest in, and rights to claim, collect, and receive the proceeds from any insurance company providing coverage for these services. Any payments received by TASC from me or my insurance company may be applied to offset any balances in my account.

Acknowledgment of Financial Responsibility

I understand that some or all of the services provided to Client by TASC may not be covered by insurance or other payor source. Except where prohibited by law, if my insurance or other payor source does not cover the services, or if my insurance or other payor source shall, for any reason, fail to pay, I acknowledge that I am financially responsible for, and I agree to timely pay, all charges for services (including any deductible or co-payment) provided to Client.

I understand that misrepresentation of this information may make me legally responsible for payment of TASC charges for services. I certify that the information given by me for purposes of payment for Client's treatment at TASC is, to the best of my knowledge, complete and accurate.

I understand that I have the right to inspect and copy the information to be disclosed. I will be given a copy of this authorization for my records.

____

Client Signature Date

____

Client's Parent/Guardian/Authorized Representative Name (please print)

____

Client's Parent/Guardian/Authorized Representative Signature Date

____

Responsible Party/Insured Name (please print)

____

Responsible Party/Insured Signature Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.)___________________________________

❑ Check here if client or financially responsible person refuses to sign authorization

____

Staff or Witness Attesting to Identity Signature Date

THIS FORM MEETS ALL REQUIREMENTS OF 42 CFR PART 2, 45 CFR PART 160 & 164 (HIPAA) AND **THE ILLINOIS MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CONFIDENTIALITY ACT.**

For Internal Use:

Client Name (Last, First): ___________________________________ **Client Date of Birth:** __________________________