University of Iowa
Assessment and Counseling Clinic
The Connie Belin & Jacqueline N. Blank International Center for Gifted Education and Talent Development

AUTHORIZATION FOR RELEASE OF INFORMATION AND PAYMENT REQUEST

PATIENT NAME: _____ EFFECTIVE DATE: _____

The University of Iowa Assessment and Counseling Clinic (ACC) of the Connie Belin and Jacqueline N. Blank International Center for Gifted Education requests this information for the purpose of identifying third-party sources (such as insurance) of payment and complying with their requirements for information on which their payments will be based. If you fail to provide the required information, we may not be able to submit these charges to the patient's insurance carrier(s).

RESPONSIBILITY FOR PAYMENT FOR SERVICES

I, the undersigned, accept responsibility for and guarantee full and timely payment to the University of Iowa Assessment and Counseling Clinic of the Belin-Blank Center for Gifted and Talented for services provided by the ACC. If I lack insurance coverage for these services or if I am otherwise unable to pay for them, I agree to advise the Clinic so that I may be assisted in the processes of applying for any financial assistance which may be available to me.

In consideration of the services provided, I assign to the ACC all of my rights and claims for reimbursement arising under any Medicaid, any other federal or state, local, or other governmental funding programs, or any private group/individual accident or health insurance policy, employer insurance groups or health plans, any intermediaries, HMO, PPO, or other third party payors, for which benefits may be available for payment of the services provided. I agree to pay the balance of the charges, which are not reimbursed by the payor including but not limited to any deductibles, co-pays, non-covered services, services not covered as a result of my failure to obtain pre-authorization for treatment as required by any such payor, or agreed upon services deemed as medically unnecessary by the payor (such as preventive or screening services).

AUTHORIZATION OF RELEASE OF INFORMATION FOR PAYMENT PURPOSES

Furthermore, I authorize the ACC to disclose and deliver any or all information in their possession relative to diagnosis, treatment, consultations, prescriptions, medical history, and copies of all necessary records, including those involving diagnosis and treatment of mental health and substance abuse, to my insurer, Medicare/Medicaid, or any other federal or state, local, or other governmental funding programs, or any private group/individual accident or health insurer, employer insurance groups or health plans, any intermediaries, HMO, PPO, or other third party payors, or their authorized representatives as is necessary for payment of the services provided to the patient. A Photostat or FAX copy of this authorization shall be considered as effective and valid as the original. This authorization is valid for releases of information made on or after the effective date unless revoked by the patient or the patient's representative (such as the parent). I understand that I may revoke this consent to release medical information at any time by sending a written notice to the Assessment and Counseling Clinic, 500 Blank Honors Center, Iowa City, Iowa 52242-0454. I may review the disclosed information at any time by contacting the Assessment and Counseling Clinic at the address above. I understand that the information to be released may include information in the following categories unless I specifically deny the release (***initial*** any category ***not*** to be released).

_____ Substance Abuse

_____ Mental Health (valid for two years)

_____	_____	_____
SIGNATURE OF PATIENT/RESPONSIBLE PERSON	DATE SIGNED	RELATIONSHIP/LEGAL TITLE, IF NOT PATIENT
_____	_____	_____
VERBAL CONSENT DATE	WITNESS	WITNESS