AUTHORIZATION AND CONSENT FOR DISCLOSURE OF PROTECTED HEALTHCARE INFORMATION TO MEDICAL OR OTHER INSURANCE CARRIERS

Client Name:_____ Client D.O.B.:_____

Primary Insurance Carrier:_____ ID#_____ Group#:_____

Secondary Insurance Carrier:_____ ID#_____ Group#:_____

I acknowledge that *Matthew J. Mauriello, MA, P.C.* (DBA "The Mauriello Group) must necessarily disclose protected health information (PHI) regarding my and/or my child's care to the above-named insurance carrier(s) if I choose to use the medical, mental/behavioral healthcare, substance abuse, and/or employee assistance program benefits provided by the insurance carrier(s). Once the PHI is submitted, I have been advised and understand that *Matthew J. Mauriello, MA, P.C.*, will have no control over it, and cannot guarantee it will be appropriately safeguarded by the insurance carrier(s), nor can *Matthew J. Mauriello, MA, P.C.* control how the PHI will be used. I understand that *Matthew J. Mauriello, MA, P.C.* may be asked to share with the insurance carrier(s) all PHI in my health information file, including any personal case notes or treatment progress notes.

As a client and/or parent of a client, I hereby authorize and consent for *Matthew J. Mauriello, MA, P.C.*, and members of its staff to disclose any and all PHI regarding my and/or my child's healthcare treatment, including but not limited to: symptoms, diagnoses, case and treatment progress notes, treatment plans, evaluations, results of assessments/testing, service delivery dates, and billing records as requested or required by the above-named insurance carrier(s). I further authorize *Matthew J. Mauriello, MA, P.C.* to bill my insurance carrier(s) for services rendered as well as to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services rendered. I assign directly to *Matthew J. Mauriello, MA, P.C.* and its staff all medical benefits; I authorize the use of my signature below on all my insurance claim submissions. If my insurance carrier(s) will not direct payment for services rendered to *Matthew J. Mauriello, MA, P.C.*, I agree to forward any and all payments I receive from my insurance carrier(s) to *Matthew J. Mauriello, MA, P.C.* If my insurance carrier(s) does not cover any charges or fees for rendered services for any reason, then I agree that I am financially responsible for all outstanding balances.

I agree to not send a member claim or copy of a receipt for a copay, coinsurance, or deducible to my primary insurance carrier if *Matthew J. Mauriello, MA, P.C.* is billing my primary insurance plan because a primary carrier does not reimburse these fees. I understand that per contract between *Matthew J. Mauriello, MA, P.C.* and my insurance carrier(s) that a copay, coinsurance, or deducible payment cannot be waived. I understand that insurance carriers may make receiving payment for services difficult, and *Matthew J. Mauriello, MA, P.C.* appreciates and expects my voluntary cooperation with insurance billing concerns.

I acknowledge and understand that I am waiving my right to confidentiality with respect to the records and PHI requested by my insurance carrier(s), and hereby release *Matthew J. Mauriello, MA, P.C.* and its staff from any and all liability arising from release of the records and PHI requested. I understand that the subscriber of the insurance policy (e.g., a parent, a spouse) will be provided with a written Explanation of Benefits (EOB) from the above-named insurance carrier(s) if it pays for or is used to cover any rendered services; this EOB will be provided even if I do not authorize any release of my PHI to that subscriber.

I understand the PHI is to be provided at my request for use by my insurance carrier(s) for determining eligibility, coverage, benefits, and payment of healthcare services rendered to me and/or my child. I know that coverage is routinely limited to services needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards also known as medical necessity. This authorization shall expire upon the termination of my therapeutic relationship with *Matthew J. Mauriello, MA, P.C.*, and upon payment by the insurance carrier(s) or by myself for any and all outstanding charges or fees for services rendered.

I acknowledge that I have the right to revoke this authorization in writing at any time to the extent *Matthew J. Mauriello, MA, P.C.*, has not taken action in reliance on this authorization. I further acknowledge that even if I revoke this authorization, the use and disclosure of my PHI could possibly still be disclosed under law to secure payment for the services provided as indicated in the copy of the Notice of Privacy Practices (NPP) of *Matthew J. Mauriello, MA, P.C.*, that I have received and reviewed. I also understand that my insurance carrier(s) may access my PHI as part a routine or random audit of *Matthew J. Mauriello, MA, P.C.* even after my and/or my child's discharge as client/patient and payment of all outstanding balances.

I acknowledge that I have been advised by *Matthew J. Mauriello, MA, P.C.*, of the potential of the redisclosure of my PHI by the authorized recipients and that it may no longer be protected by the federal Privacy Rule. I further acknowledge that the treatment and services provided to me by *Matthew J. Mauriello, MA, P.C.* was not conditioned on my signing this authorization, and that I was provided with the option to pay for any medically necessary services personally; however, I have chosen to access my insurance benefits and requested *Matthew J. Mauriello, MA, P.C.* to bill my above-named insurance carrier(s) directly for services. I further certify that the information I provided above about my insurance carrier(s) is current, accurate, and complete as well as that no other coverage or insurance exists at this time. I also agree to immediately inform *Matthew J. Mauriello, MA, P.C.* of any future changes to my current coverage and/or insurance information.

_____ _____ _____

Signature of client / client representative | Printed name | Date

I, a behavioral health professional, have discussed the issues above with the identified client/patient and/or his or her parent or legal guardian. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing authorization and consent.

_____ _____ _____

Signature of professional | Printed name of professional | Date