Authorization to Bill

The Steven A. Cohen Military Family Clinic at (clinic's name) works in affiliation with Cohen Veterans Network, Inc. (CVN) [a 501(c)(3) nonprofit organization] to help fill gaps in mental health care for post-9/11 veterans, service members, and family members. While the clinic is supported by CVN's philanthropy, funding is not unlimited and we are committed to the sustainability of our model. As such, **The Steven A. Cohen Military Family Clinic at (clinic's name)** will bill a client's insurance and collect co-payments as appropriate to help extend the reach of the Cohen Clinic to ensure we can continue to provide services to veterans, service members, and their family members in the future. Should you/your family encounter financial hardships, we will work with you to make sure that the ability to pay is not a barrier to receiving the care you or your family need.

Client Legal Name: _____ Client DOB: _____

Responsible Party Name (if different): _____

_____ **I have health insurance and agree that the Steven A. Cohen Military Family Clinic at (clinic's name) can submit claims for reimbursement from my insurance for any and all billable services provided**. I authorize the Cohen Clinic to release any information needed by my insurer to appropriately process claims submitted on my behalf. I further understand that I am responsible for any required payment (such as co-payments, co-insurance, and deductibles). Co-payments are expected to be paid at the time of service or upon receipt of a billing statement. I agree to be billed for any remaining balances not paid by my health insurance. I understand it is my responsibility to notify the Cohen Clinic staff of my desire to relinquish this authorization, if there are any changes in my insurance, or if my financial situation changes during the course of my treatment.

_____ **I have health insurance, but I do not want my insurance billed.** I understand that I will be responsible for the total cost of my care and will make financial arrangements with the Steven A. Cohen Military Family Clinic at (*clinic's name*).

_____ **I am not covered by any health insurance policy**, through myself or any source at this time of treatment. I understand that I am responsible for the total cost of my care and will make financial arrangements with the Steven A. Cohen Military Family Clinic at (*clinic's name*). I further understand that I may request financial assistance **via the Cohen Compensated Care Fund Request for Assistance Form ("I do not have insurance" option)**. Should any insurance become effective during my treatment I will notify the Cohen Clinic staff.

FRAUD WARNING:
Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other persons, files a statement of claim containing false, incomplete, or misleading information may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

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Client's or Responsible Party Signature: Date:

_____ _____