Consent For Release of InformationTo Insurance Company

The undersigned authorizes Alpine Clinic, LLC to release all patient information, including specific information regarding diagnosis, treatment, and prognosis with respect to any physical, psychiatric, or drug/alcohol related condition for which the patient is being treated, to any insurance company, and/or third party payers, or representative providing coverage. This information may not be released to any other person or entity unless the undersigned so authorizes.

The undersigned further authorizes Alpine Clinic, LLC to release information for the purpose of obtaining pre-authorization for treatment and concurrent review and to release that information to medical review agencies, and/or third party payers providing coverage or having responsibility for the treatment.

The undersigned acknowledges that this authorization shall be valid until all third party payers' liability is resolved for treatment.

Financial Agreement
The undersigned hereby agrees as follows:

1. **GUARANTEE OF PAYMENT**: The physician or healthcare professional identified above has been or will be providing care to the patient whose name appears below. The undersigned, hereby agree(s) to guarantee the payment of the bill for services rendered by physician or healthcare professional. The undersigned agree(s) whether signing as guarantor or as patient, that in consideration of the services to be rendered to the patient to be hereby jointly and individually obligated to pay the account of the physician or healthcare professional in accordance with the regular rates and terms of the physician or healthcare professional. Should the account be referred to collection by an attorney or collection agency, the undersigned agree(s) to pay all attorney's fees and other reasonable collection costs and charges that are necessary for the collection of any amount(s) not paid when due.
2. **ASSIGNMENT OF INSURANCE BENEFITS**: In consideration of medical services rendered or to be rendered by physician or healthcare professional, to the extent permitted by law, I hereby (I) irrevocably assign, transfer and set over to physician or healthcare professional (II) all of my rights, title and interest to medical reimbursement, including, but no limited to, (III) the right to designate a beneficiary, add dependent eligibility and (IV) t have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by physician or healthcare professional during the pendency of the claim for this information. Such irrevocable assignment and transfer shall be for the recovery on said policy(ies) of insurance, but shall not be construed to be an obligation of physician or healthcare professional to pursue any such right of recovery. I hereby authorize the insurance company(ies) or third party payer(s) providing coverage for services to pay directly to physician or healthcare professional all benefits due for service rendered.
3. **INSUFFICIENT INSURANCE COVERAGE**: If any insurance of other third party coverage which the patient may have rejects the patient's claim or pays only part of the claim, the undersigned shall be responsible for payment of the balance due, as determined by the physician or healthcare professional.
4. The undersigned acknowledges that this agreement has been read and is understood.

Patient's Name: ____
Please Print

______________________________ ____________________ ________________________
Name of Guarantor – Please Print | Relationship to Patient | Signature of Guarantor

____ ______________________
Home Address Street, City, State, Zip | Telephone Number

____ ______________________
Employer's Name, Address | Telephone

____
Home E-mail Address for Confirmation of Appointments.

____ ______________________
Signature of Witness (if required) | Date

01/15/2014