NEWPOT INTEGRATED BEHAVIORAL HEALTHCARE, INC.
1810 MOSERI RD, DECATUR, GA 30032
404-289-8223 FAX: 404-286-7009

English - Spanish

FINANCIAL ACKNOWLEDGEMENT

ASSIGNMENT OF BENEFITS: In consideration of the services provided at Newport Integrated Behavioral HC, I THESE LINES hereby assign and transfer to the Facility and other clinical providers all behavioral and medical provider benefits payable under my insurance policies or benefit plans. I hereby assign and transfer all related rights and remedies due under the insurance policies or benefit plans that I have identified or will identify in connection with all services rendered, including but not limited to all rights and remedies pursuant to applicable state, federal and ERISA regulation. I hereby assign and transfer all rights to the Newport and other medical providers applicable under ERISA, federal or state regulation to pursue any benefit denial, limitation of coverage or request for an administrative review of fiduciary duties involving administration of benefits by the U. S. Dept of Labor, the Department of Community Health or the Department of Insurance. I authorize and direct the insurance company to pay all such benefits to the Newport Integrated Behavioral Healthcare and appropriate clinical providers. I understand that assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurance company and the Facility.

PRECERTIFICATION: I understand that my insurance policy may require compliance with a utilization review program to make certain that health care benefit funds are expended when justified. **I understand** that it is the utilization review program's responsibility to review proposed elective admissions and anticipated courses of treatment. **I understand** that if the utilization review program determines that admission is necessary and appropriate and issues certification, the benefits of my health plan will be made available to me in accordance with the terms of my policy. However, if certification is denied, health care benefits may be withheld. **I understand** that precertification may be the responsibility of the patient or financially responsible party and his or her physician. **I understand** that Newport Integrated Behavioral Healthcare, Inc is willing to admit as requested by my psychiatrist. **I also understand** that I may be financially responsible for all residential charges incurred as a result of admission should the utilization review program refuse to certify that the admission is appropriate, or should the certification effort occur too late to be valid. **I understand** that to protect myself from unnecessary personal financial losses, I must provide insurance coverage at time of registration, review my obligations with my insurance company, utilization review program, and personal physician without delay.

ABOUT YOUR BILLING:

Facility and Provider-Based Services — A bill will be received for the professional component of treatment. Although Newport Integrated Behavioral Healthcare may be a provider in an insurance network, the physician or professional service provider may or may not be a covered provider of service. If the care received is outpatient care, the insurance carrier will process the claim(s) on an outpatient basis. Outpatient services may require co-insurance, deductible and/or co-pay, depending on insurance policy benefits.

FINANCIAL RESPONSIBILITY: Payment in full is expected at the time services are received. Accounts more than 30 days past due will accrue interest at the rate of 8 percent a year. This interest does not apply to deductibles/copayments of Medicare/Medicaid or other governmental programs. **(Accounts under an agreed alternate payment contract will not be considered past due, provided the plan is accepted in writing.)** Insured patients are required to pay identified co-pay, unsatisfied deductible, and estimated co-insurance prior to any elective services unless alternate arrangements are made. Uninsured patients are required to make payment in full prior to any elective services unless alternate arrangements are made. This provision does not apply, and payment will not be requested, prior to emergency screening and stabilizing treatment as required by federal law.

_____ **I authorize Newport Integrated Behavioral Healthcare, Inc., or any of its providers, agents, contractors or business associates, to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by pre-recorded forms of voice/ messaging systems, by electronic mail owned or used by the guarantor/responsible party, by text messages, by telephone or by cell phone for reasons related to the services I received at Newport Integrated Behavioral Healthcare, Inc or payment for the services I received at Newport Integrated Behavioral Healthcare, Inc., including but not limited to, debt collection purposes. I further understand and acknowledge that my consent in receiving the aforementioned communications is not required nor is it a preceding condition to receiving health care services at Newport Integrated Behavioral Healthcare, Inc.**

_____ **I do not agree with the above statement and do not wish to be contacted except for clinical issues.**

By signing below, I acknowledge and agree that I have read or had this form read to me and I understand and agree to its contents.

_____ _____
PATIENT / REPRESENTATIVE DATE RELATIONSHIP TO PATIENT

Interpreter Signature _____
Note: If phone interpretation used, record interpreter ID #

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge receipt of the Notice of Privacy Practices from Newport Integrated Behavioral Healthcare, Inc. The Notice of Privacy Practices provides information about how Newport Integrated Behavioral Healthcare, Inc and staff members may use and disclose my health information. I have been encouraged to read the notice in full.

I understand that the Notice of Privacy Practices is subject to change. If Newport Integrated Behavioral Healthcare, Inc changes its notice, I may obtain a copy of the revised Notice on site and/or at Newport's website (www.nibhinc.com).

_____ _____
PATIENT / REPRESENTATIVE DATE RELATIONSHIP TO PATIENT

INABILITY TO OBTAIN ACKNOWLEDGEMENT FOR RECEIPT OF PRIVACY PRACTICES

☐ **Patient/Representative refused to sign** ☐ **Patient not competent to sign and legal representative not present** ☐ **Other** _____

Interpreter Signature _____
Note: If phone interpretation used, record interpreter ID #