



**Mat Su Health Services, Inc**

1363 W Spruce Avenue

Wasilla, AK 99654

(907) 376-2411

**Financial Responsibility and Consent Form**

\_\_\_\_ I consent to receive services by a team of professionals; I understand that health information may be shared between the Primary Care Clinic and Behavioral Health Services in order to coordinate care.

\_\_\_\_ Mat Su Health Services (MSHS) will bill my insurance. I will pay for services denied by my insurance or Medicaid. I will pay any co-pays, deductibles, or amount not paid by my insurance at time of service. If I have a pending application for Medicaid, I will tell MSHS what Medicaid decides. I am responsible for fees before the start of Medicaid. If I do not get Medicaid, I am responsible for paying the MSHS fees.

\_\_\_\_ I will give MSHS current information including insurance, contact, income, and a sticker each month I am eligible for Medicaid. I will tell MSHS about any changes to my insurance, income, or contact information.

\_\_\_\_ I authorize MSHS to release to the Social Security Administration and Health Care Financing Administration, my insurance company, or any intermediaries, carriers, and agents, any information needed to determine the eligibility or benefits for this or any related claim and to process the payment of claims. Also, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

\_\_\_\_ I understand that in order to take advantage of any discount programs, I must provide proof of income on an annual basis. If I fail to provide proof of income, in a timely manner, I will be responsible for the full fee for service. I understand that I am responsible for all charges, fees and costs associated with the services I receive.

\_\_\_\_ I acknowledge that I have been offered a copy of MSHS Notice of Privacy Practices, which states how my health information may be used and/or disclosed. I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice. If I am not the person receiving healthcare services, I represent that I am authorized by law to act for and on that person's behalf.

I understand and agree to these statements.

\_\_\_\_\_  
Client or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## Restatement of Financial Responsibility:

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I authorize MSHS to release to the Social Security Administration and Health Care Financing Administration, my insurance company, or any intermediaries, carriers, and agents, any information needed to determine the eligibility or benefits for this or any related claim and to process the payment of claims. Also, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I understand that in order to take advantage of any discount programs, I must provide proof of income on an annual basis. If I fail to provide proof of income, I will be responsible for the full fee for service. I understand that I am responsible for all charges, fees and costs associated with the services I receive.

I certify that the information I have provided is true and correct to the best of my knowledge.