KOKUA Lifestyle and Nutrition

Authorization to Bill Insurance, Release of Information, and Payment Request

Patient Name _____

Birth Date _____/_____/_____

A. Insurance, Payment Information and Assignment of Benefits: I request Kokua Lifestyle and Nutrition/Shelby Erin Slenkamp MS, RDN, CD to submit claims on my behalf to my insurance company, Medicare, or other third party payor for my care and authorize the disclosure of health information to the extent necessary to obtain payment services rendered. In consideration of the health care services provided to the patient, I assign and authorize my insurance company, Medicare, or other third party payor to make payments directly to Shelby Slenkamp including charges for all services. In consideration of the health care services provided to the patient, I assign to Shelby Slenkamp any medical benefits to which I may be entitled to receive, including without limitation any such benefits due or claims I have under or pursuant to a health care employee benefit plan, governed under ERISA, 29 USC sec. 101 et seq.

*I have been informed that: I must pay all charges, co-payments, deductibles, and coinsurance not covered by my insurance company, Medicare, or third party payor. I must pay all charges incurred if I lack insurance coverage and will also contact Shelby Slenkamp to identify financial options available for me.

I may revoke this consent to release medical information at any time by sending Shelby Slenkamp a written and signed notice. I agree to pay for non-covered services or services not covered as a result of my failure to obtain pre-authorization for treatment as required by any such payor, or agreed upon services deemed as medically unnecessary by the payor. We will use good faith efforts to protect patient's right to confidentiality in appropriately providing health information to payers.

B. Specific Authorization for Release of Information: I specifically authorize Kokua Lifestyle and Nutrition/Shelby Erin Slenkamp MS, RDN, CD to submit medical information regarding diagnoses, treatment, consultations, prescriptions, and medical history to my insurance company, Medicare, or other third party payor or its authorized agents or representatives for the purpose of determining benefits and facilitating payment. This authorization allows release of past and future information and will expire two years from the date of signature, unless cancelled by the patient/guardian. I may revoke this specific consent to release information at any time by sending a written and signed notice. I understand that the information may be released electronically.

I understand that it is my responsibility, as named patient, to verify my benefits before receiving services.

_____ _____/_____/_____

Patient or Legal Guardian Signature Date

_____

Relationship, if Not the Patient