



**Diligence Behavioral and Medical
Integrated Healthcare, a Professional
Nursing Corporation (Diligence Care Plus)**

255 N. D Street, Suite 400
San Bernardino, CA 92401
Phone: 909-276-1198; Fax 909-206-0636

Credit/Debit Card Payment Consent Form

Financially Responsible Party Name: _____
First MI Last

Name on Card if different _____

I authorize Diligence Behavioral and Medical Integrated Healthcare, a Professional Nursing Corporation, dba Diligence Care Plus, to charge my card for professional services as follows:

Please Initial: _____

Any agreed-on session or service that is not paid for at the time service is rendered, unless other arrangements have been made for payment or I have a dispute concerning the service or payment for that service. No debits will be processed on my card until the dispute is resolved. I have been informed that all information provided here will never be shared with any other parties, and that it will be stored and transmitted according to strict encryption protocols and meet all federal HIPAA requirements for privacy.

Type of Card:

VISA MasterCard Discover Amex

Card Number _____ - _____ - _____ - _____

CSC/Security Code# _____

Exp. Date _____

Card Holder's Billing Address for Monthly Card Statements:

Street City State Zip

Card Holder Signature _____ Date ____ / ____ / ____

*If I have questions about these charges, I agree to first contact my provider (Diligence Care Plus). I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider. Please note that to be considered a valid card an HSA card must be tied to a funded account.

FORM P-104: AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Information (Please Print)

Patient's Name: _____

Address: _____

Patient Identification Number: _____ Date of Birth: _____ (MM/DD/Year)

Group or Account # on ID card: _____

Phone number where we can reach you to process your request (required) : (_____) _____ - _____

SECTION B: Information Regarding This Authorization

I, or my authorized representative, request that health information regarding my care and treatment be used and disclose as set forth on this form. In accordance with State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG TREATMENT, MENTAL HEALTH TREATMENT**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION** and **GENETIC INFORMATION** accordance with applicable law and only if I initial the appropriate place in Section F. In the event the health information described below includes any of these types of information, and I initial the appropriate place in Section F, I specifically authorize release of such information to the person(s) indicated in Section D.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient, and this re-disclosure may no longer be protected by federal or state law. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization, unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the State Division of Human Rights. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the entity listed in Section C below. I understand that I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization prior to my withdrawal.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

SECTION C: Person or Company Who Will Receive This Information

Name, relationship (if applicable), address, telephone and fax numbers of person(s) or entity/category of person to whom this information will be disclosed:

SECTION D: Purpose of This Disclosure

Reason(s) for releasing information under this authorization:

FORM P-104: AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

SECTION E: Information That Can Be Released	
I authorize the following information to be used or disclosed on my behalf:	
<input type="checkbox"/> All my information. This may include health information, claims information, enrollment information or financial information, with the exception of sensitive information.	
OR	
<input type="checkbox"/> Only limited information (check all that apply):	
<input type="checkbox"/> Claims Information	<input type="checkbox"/> Enrollment Information
<input type="checkbox"/> Other Information: _____	
<input type="checkbox"/> Limited to the following conditions: _____	
<input type="checkbox"/> Limited to the following dates: Start Date _____ End Date _____ (MM/DD/YEAR)	
I also authorize the use or release of the following types of sensitive information <i>(please select all that apply)</i> :	
<input type="checkbox"/> Mental Health Related Information	<input type="checkbox"/> HIV/AIDS-Related Information
<input type="checkbox"/> Alcohol/Drug Treatment Information	<input type="checkbox"/> Genetic Information
<input type="checkbox"/> Limited to the following conditions: _____	
<input type="checkbox"/> Limited to the following dates: Start Date _____ End Date _____ (MM/DD/YEAR)	
SECTION F. Expiration of Authorization	
This approval will end on the earlier of:	
<input type="checkbox"/> Date: _____ (MM/DD/YEAR)	
OR	
<input type="checkbox"/> Upon termination of enrollment	
SECTION G: Review and Approval	
I have reviewed the contents of this form. I understand, agree and allow to use and release my information as described above.	
Patient Signature	Date
X	
Legal Guardian/Representative Information	
Name: _____ (Print) _____ (Signature)	
Relationship to Individual: _____ Date: _____	
<i>Please note: If you are a personal representative for the Patient, you must attach copies of your authorization as required by state law to represent the Patient – for example, power of attorney, health care proxy or guardianship papers.</i>	

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Address: _____

Patient Identification Number: _____ Date of Birth: _____ (MM/DD/Year)

Group or Account # on ID card: _____

Phone number where we can reach you to process your request (required) : (_____) _____ - _____

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2. With some exceptions, health information once disclosed may be re-disclosed by the recipient, and this re-disclosure may no longer be protected by federal or state law. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization, unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the State Division of Human Rights. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the entity listed in Section C below. I understand that I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization prior to my withdrawal.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

SECTION C: Person or Company Who Will Receive This Information

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SECTION D: Purpose of This Disclosure

Reason(s) for releasing information under this authorization:

FORM P-104: AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

SECTION E: Information That Can Be Released

I authorize the following information to be used or disclosed on my behalf:

All my information. This may include health information, claims information, enrollment information or financial information, with the exception of sensitive information.

OR

Only limited information (check all that apply):

Claims Information

Enrollment Information

Other Information: _____

Limited to the following conditions: _____

Limited to the following dates: Start Date _____ **End Date** _____ **(MM/DD/YEAR)**

I also authorize the use or release of the following types of sensitive information *(please select all that apply)*:

___ Mental Health Related Information

___ HIV/AIDS-Related Information

___ Alcohol/Drug Treatment Information

___ Genetic Information

Limited to the following conditions: _____

Limited to the following dates: Start Date _____ **End Date** _____ **(MM/DD/YEAR)**

SECTION F. Expiration of Authorization

This approval will end on the earlier of:

Date: _____ (MM/DD/YEAR)

OR

Upon termination of enrollment

SECTION G: Review and Approval

I have reviewed the contents of this form. I understand, agree and allow to use and release my information as described above.

Patient Signature

X

Date

Legal Guardian/Representative Information

Name: _____ (Print) _____ (Signature)

Relationship to Individual: _____ Date: _____

Please note: If you are a personal representative for the Patient, you must attach copies of your authorization as required by state law to represent the Patient – for example, power of attorney, health care proxy or guardianship papers.

PATIENT ELECTION TO SELF-PAY FOR SERVICES

I, the undersigned patient, acknowledge that I understand and agree that:

1. Provider with Diligence Care Plus is a participating provider with my insurance plan (name of insurance carrier/company)
2. I am covered by one of (name of insurance) health insurance plans. **NOTE:** Patient who have Medicare can not use this form.
3. The health plan under which I am covered includes benefits for some or all the services provided by Diligence Care Plus
4. Despite the above, I do **NOT** wish Diligence Care Plus to submit a claim to my insurance carrier for services provided to me by Diligence Care Plus.
5. Until such time as I may otherwise advise Diligence Care Plus in writing, I elect to pay for all services I receive from Diligence Care Plus at their cash price or discounted rates.
6. By election to self-pay for services, any payments I make to Diligence Care Plus will not be credited toward satisfying any deductible or copay I may be subject to under my health insurance plan unless otherwise permitted under the terms of my health plan.
7. I have read this Election to Self-Pay for Services form and have had the opportunity to ask any questions I may have had about the form. Any questions I may have had about this form have been answered to my satisfaction.
8. I have freely chosen to self-pay for services after having asked Diligence Care Plus about payment options and having carefully considered those options.
9. I do NOT have **Medicare** as my insurance carrier/health plan (initial here)

Date: _____

Patient: _____

Signature of patient or responsible party if patient is a minor or is otherwise unable to sign for him/herself

Printed Name of Patient or Responsible Party/Relationship

REVOCATION OF PATIENT ELECTION TO SELF-PAY FOR SERVICES

I,, the undersigned patient, acknowledge that I understand and agree that:

1. I previously signed a Patient Election To Self-Pay For Services on (date signed)
2. I continue to be insured under a health insurance plan offered by (name of insurance carrier/health plan with which Diligence Care Plus continues to participate.
3. By my signature below, I revoke my earlier election to self-pay for services and direct Diligence Care Plus to begin billing my health plan for services provided by Diligence Care Plus.
4. The health plan under which I am covered may limit coverage for services provided by Diligence Care Plus and/or may subject me to a deductible that must be satisfied before any benefits are provided under the health plan.
5. I will be personally responsible for the cost of any services provided to me by Diligence Care Plus that are not covered by my health plan to the extent consistent with the terms of my health plan.
6. Diligence will bill for services at their contracted rates as a participating provider with my insurance company which may be higher than the Self-pay or discounted rate Diligence Care Plus makes available to patients who self-pay for services.
7. I have read this Revocation of Patient Election to Self-Pay for Services form and have had the opportunity to ask any questions I may have had about this form. Any questions I may have had about this form have been answered to my satisfaction.

Date: _____

Patient: _____

Signature of patient or responsible party if patient is a minor or is otherwise unable to sign for him/herself

Printed Name of Patient or Responsible Party/Relationship