

Date : _____

Client Name: _____

C.I.N. #: _____

SS#: _____ DOB: _____

Sierra County Behavioral Health Financial Form

Information from: Patient Responsible Person

New Readmit Update

Financial Type: Individual Family

Program: Mental Health Substance Abuse Both

Name: _____ Relationship: _____

Billing Address: _____ City/Zip: _____

Home Phone #: _____ Cell Phone : _____

Employer: _____ Work Telephone #: _____

Other Source of Income: _____

Primary Insurance Company: _____ Veteran: _____ Claim No.: _____

Secondary Insurance Company : _____

Family Members In Treatment:

- _____
- _____
- _____

<u>Income</u>	
Gross Monthly Income	
Self	\$ _____ .00
Spouse	\$ _____ .00
Other: SS, Public Assist	\$ _____ .00
Unemployment, Disability	
Sub-Total (A)	\$ _____ .00

<u>Expenses</u>	
Allowable Expenses	
Court Ordered	\$ _____ .00
Child Care	\$ _____ .00
Med. Exp. in excess of 3%	\$ _____ .00
Mandated Deductible	\$ _____ .00
Total (B)	\$ _____ .00

Household Size (including self): _____

FOR OFFICE USE ONLY

Calculation of Annual Deductible Income

A. Subtotal - Gross Mo. Income	\$ _____ .00
B. Total Allowable Expenses	\$ _____ .00
E. Total Income (A-B)	\$ _____ .00
F. MH Annual Liability	\$ _____ .00
G. Substance Abuse Sliding Scale	\$ _____ .00

UMDAP Valid _____ Through _____
(Uniform Method of Determining Ability to Pay)

Payment Plan Agreed Amount: \$ _____

Per : Month Visit

*****Agreement to Pay Amount Due*****

I affirm that the statements made herein are true to the best of my knowledge. I understand and accept my annual deductible and agree to pay the amount due on a timely basis.

*****Assignment of Benefits-Release of Information*****

I hereby assign all Behavioral Health Benefits to which I am entitled including Medi-Cal, Medicare, to Sierra County Department of Health and Human Services. This assignment will remain in effect until revoked by me in writing or until such time as I am no longer receiving Sierra County Behavioral Health Services. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible to pay any deductible amount referred to above if charges are not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

SIGNED: _____ DATE: _____
Patient or Responsible Person

BH Representative: _____ DATE: _____

Sierra County Health & Human Services

AUTHORIZATION FOR RELEASE OF INFORMATION



A photocopy/facsimile copy may be used as an original

Your Information

Last Name	First Name	Middle Initial

Street Address	P.O. Box	City/State	Zip

Person/Organization Providing Information:

Person/Organization Receiving Information:

Name: _____
Position or Role: _____
Address: _____
City/State/Zip: _____
Phone #: _____ Fax#: _____

Sierra County Behavioral Health
704 Mill Street | P.O. Box 265
Loyalton CA 96118
PH: (530) 993-6746 FAX: (530) 993-6759

Description of Information to be Released

(Provide a detailed description of the specific information to be released.)

[45 C.F.R. § 164.503(c)(1)(i) | CA Civil Code § 56.11(d), and (g)]

Check each type of confidential information you authorize to be released:

HIV or AIDS Information

Alcohol/Drug Information

Mental Health / Behavioral Health

Genetic Testing Information

Other: _____

Specifically, _____

For the following period of time: from _____ (date) to _____ (date).

Description of the Purpose and Limitations for the Use or Release of the Information

(Indicate how information will be used.)

[45 C.F.R. § 164.508(c)(1)(iv) | CA Civil Code § 56.11(g)]

_____ The information will not be used for any purpose other than its intended use. _____

Will the health plan or provider receive money for the release of this information?

[45 C.F.R. § 164.524(c)(4)]

Yes

No

* * * Reasonable fees may be charged to cover the costs of copying and postage. * * *

This authorization for release of the above information to the above named persons or organizations will expire on: _____ (date).

I understand that:

- I authorize the use and/or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary.
- I have the right to revoke this authorization at any time by sending a signed notice stopping this authorization to **Sierra County Behavioral Health at 704 Mill Street | P.O. Box 704; Loyalton CA 96118**. The authorization will cease on the date my valid revocation request is received.
- The notice of Privacy Practices provides instructions for me should I choose to revoke my authorization and includes limitations on my revocation.
- My treatment, payment, enrollment, or eligibility for benefits will not be affected if I do not sign this authorization.
- Under California law, the recipient of my medical information is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law.
- If the organization or person I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I have the right to receive a copy of this authorization.

Records and copies obtained relating to outpatient psychotherapy care shall be returned or destroyed at the expiration date of this authorization except those obtained for treatment and diagnosis purposes.

Patient Signature: _____ Date: _____

Patient's (Personal) Relationship: _____ Date: _____
 Representative Signature: _____

Sierra County Health & Human Services

AUTHORIZATION FOR RELEASE OF INFORMATION



A photocopy/facsimile copy may be used as an original

Your Information

Last Name	First Name	Middle Initial
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Street Address	P.O. Box	City/State	Zip
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Person/Organization Providing Information:

Sierra County Behavioral Health

704 Mill Street | P.O. Box 265

Loyalton, CA 96118

PH: (530) 993-6746 FAX: (530) 993-6759

Person/Organization Receiving Information:

Name: _____

Position or Role: _____

Address: _____

City/State/Zip: _____

Phone#: _____ Fax#: _____

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Patient Signature:

Date:

Patient's (Personal)
Representative Signature:

Relationship:

Date: