Lemon-AID
Medical Management

AUTHORIZATION TO RELEASE BILLING INFORMATION & ASSIGNMENT OF BENEFITS

This form covers insurance, billing, and payment for care you receive at Lemon-AID Medical Management. A separate form covers your consent to receive care: the Consent to Treat & Electronic Consent. You may find a copy of our Lemon-AID Medical Management Welcome Form and the Joint Notice of Privacy Practices Form on our website and patient portal. If you would prefer a paper copy for your records, please request this at the time of registration.

ACKNOWLEDGEMENT OF TRUE AND ACCURATE INFORMATION

The information reported in this document is accurate to the best of my knowledge. I hereby authorize the physicians and staff of Lemon-AID Medical Management to release any information obtained during my treatment to my insurance company or third-party payer, as required for claims filing, quality assurance, health plan administration, or complaints/grievances.

AUTHORIZATION TO RELEASE BILLING AND CLAIMS INFORMATION

I authorize Lemon-AID Medical Management, and any physician, provider, facility, laboratory, or other holder of my medical or billing information, to release to my health insurance company, health plan, third-party payer, plan sponsor, clearinghouse, and their respective agents, contractors, and subcontractors — and to any other person or entity responsible for all or part of my bill — the information needed to verify eligibility, obtain referrals or prior authorization, determine the benefits payable, file and process claims, coordinate benefits, appeal denials, and collect payment for services provided to me.

The information released under this authorization may include my demographic and contact information, insurance and eligibility information, dates and locations of service, diagnoses and diagnosis codes, procedure and service codes, itemized charges, treatment records, test and laboratory results, and any other clinical documentation reasonably required to substantiate a claim, respond to a payer's request for records, or support an appeal.

I understand that this information may be used and disclosed for payment, quality assurance, health plan administration, utilization review, care coordination, audit, and the resolution of complaints or grievances, and that Lemon-AID Medical Management will release only the information reasonably necessary for those purposes.

I understand that I am not required to sign this authorization in order to receive treatment. However, if Lemon-AID Medical Management is not permitted to release the information described above, it may be unable to bill my health plan on my behalf, and I will be responsible for payment in full.

Patient Initials: _____

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AUTHORIZATION TO RELEASE SENSITIVE INFORMATION

I specifically authorize Lemon-AID Medical Management to release information relating to HIV testing and test results, Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted infections, mental and behavioral health, and substance use disorder treatment, to the following class of persons: my health insurance company, my third-party payer, and their respective agents and contractors, solely for the purposes of claims processing, payment, quality assurance, health plan administration, and resolution of complaints or grievances. I understand this authorization must be in writing under Texas law and that I am not required to sign it as a condition of receiving treatment.

Patient Initials: _____

PERSONS AUTHORIZED TO DISCUSS MY ACCOUNT (OPTIONAL)

This section is optional. Treatment, payment, enrollment, and eligibility for benefits do not depend on whether I complete it. I authorize Lemon-AID Medical Management to discuss my account balance, statements, insurance coverage, claim and payment status, and payment arrangements with the person(s) named below, and to leave that information in a message for them.

I understand that this permission covers billing and account information only. It does not authorize Lemon-AID Medical Management to discuss my medical records, test results, diagnoses, or other clinical information, which requires a separate written authorization.

Name	Relationship	Phone number

If no one is named above, Lemon-AID Medical Management will discuss my account only with me, with my health plan and its agents, and with others as permitted or required by law.

ASSIGNMENT OF BENEFITS

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

I authorize my insurance benefits to be paid directly to Lemon-AID Medical Management, and I understand I am responsible for paying for non-covered services. I certify that the information I have provided to Lemon-AID Medical Management in applying for payment under insurance coverage or other protection is correct and complete. I authorize any holder of my medical information to release any information needed to determine the benefits payable for related services to the insurance company or its agents. This assignment will remain in effect until I revoke it in writing. A photocopy of this assignment is to be considered as valid as the original. I agree to be financially responsible for all charges. I have read and understand this information.

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Patient Initials: _____

FINANCIAL RESPONSIBILITY

I acknowledge that I am legally responsible for all reasonable charges in connection with the medical care and treatment provided by the physicians and other clinical providers of Lemon-AID Medical Management, and I promise to pay whatever charges are not paid by my health plan or insurance in return for the medical care and services that are provided. This includes all co-payments, deductibles, coinsurance, non-covered and out-of-network services, services denied by my health plan, and charges incurred after my coverage terminates.

I understand it is my responsibility to provide current and accurate insurance information, to notify Lemon-AID Medical Management of any changes in coverage, and to obtain any referrals or prior authorizations my plan requires. If my health plan denies payment because I did not provide this information or obtain the required authorization, I am responsible for the full balance.

I understand that balances not paid within thirty (30) days of statement may accrue interest at the lesser of eighteen percent (18%) per annum (one and one-half percent (1.5%) per month) or the maximum rate permitted by Texas law, and that if my account is referred for collection, I will be responsible for reasonable collection costs and attorney's fees to the extent permitted by law. I understand that appointments cancelled with less than twenty-four (24) hours' notice, or missed without notice, may be subject to a no-show fee that is not billable to my insurance. This financial responsibility is continuing and applies to all dates of service until revoked in writing.

Patient Initials: _____

CONTINUING EFFECT; TERM AND REVOCATION

CONTINUING EFFECT. I intend this document to be a general, continuing authorization and assignment. It becomes effective on the date signed below and remains in effect for all care I receive from Lemon-AID Medical Management, its physicians, advanced practice providers, employees, contractors, affiliates, and successor entities, at any of its locations, on this and all future dates of service, until I revoke it. This document does not expire with the passage of time and does not require annual renewal. I understand that where an expiration date or event is required, I have chosen a continuing authorization that expires upon my written revocation or upon the end of my treatment relationship with Lemon-AID Medical Management, whichever occurs first.

REVOCATION. I may revoke this authorization and assignment, in whole or in part, at any time by delivering a signed, written revocation to Lemon-AID Medical Management. Revocation is effective only when Lemon-AID Medical Management receives it and applies only prospectively; it does not affect any disclosure made, claim filed, payment received, action taken, or charge incurred before Lemon-AID Medical Management received the revocation. Revoking this document does not relieve me of my obligation to pay for services already provided, and does not by itself revoke my Consent to Treat.

RE-DISCLOSURE. I understand that information disclosed under this authorization may be re-disclosed by the recipient and may then no longer be protected by the federal privacy rule.

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A photocopy, facsimile, scanned image, or electronic copy of this document is as valid as the original. I agree that my electronic or digital signature has the same force and effect as my handwritten signature.

AUTHORITY TO SIGN, LANGUAGE, AND SEVERABILITY

AUTHORITY TO SIGN. If I am signing on behalf of the patient, I certify that I am the patient's parent, legal guardian, managing conservator, agent under a medical power of attorney, or other person authorized under Texas law (including Texas Family Code Chapter 32) to consent to the patient's care, and that I will promptly notify Lemon-AID Medical Management if that authority changes or ends. I understand that a minor in Texas is a person under 18 who has never been married and has never had the disabilities of minority removed by a court, and that Texas law permits certain minors to consent to their own care in limited circumstances.

LANGUAGE AND UNDERSTANDING. I have received this document in a language I understand, or an interpreter was offered to me and I have had the opportunity to ask questions. All of my questions have been answered to my satisfaction.

SEVERABILITY. If any part of this document is found to be invalid or unenforceable, the remaining parts remain in full force and effect. This document is governed by the laws of the State of Texas.

SCOPE OF THIS SIGNATURE. My single signature below applies to this entire document and to each of its sections, including: the acknowledgement that the information I provided is true and accurate; the authorization to release billing and claims information; the authorization to release sensitive information (HIV/AIDS, sexually transmitted infections, mental and behavioral health, and substance use disorder treatment) to my health plan and its agents; the Assignment of Benefits; my financial responsibility for charges; and continuing effect, term, and revocation. I do not need to sign or initial each section separately for that section to be effective. The only exception is the optional Persons Authorized to Discuss My Account section, which takes effect only for the person(s) I have listed above, and any section that expressly requires my separate initials. I intend this signature to have the same force and effect for every section as if I had signed each one individually, and to remain in effect for all future dates of service until I revoke it in writing.

If signed by someone other than the patient, complete the following:

Relationship to patient: _____

Basis of authority (check one):

_____ Parent

_____ Court-appointed guardian or managing conservator (documentation provided)

_____ Grandparent, adult sibling, or adult aunt/uncle of a minor patient

_____ Adult with actual care, control, and possession of the patient and written authorization to consent

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CERTIFICATION AND SIGNATURE

I hereby certify that I have read the above Authorization to Release Billing Information & Assignment of Benefits, initialed each section as applicable, and hereby give my authorization and consent. I understand that this document remains in effect for all future dates of service until I revoke it in writing.

_____	_____	_____
Name	Signature	Date
_____	_____	_____
Guardian Name	Guardian Signature	Date

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