

Cove Center for Recovery, LLC.

Client Name: _____ MR#: _____

Assignment of Benefits / Release of Medical Information

I hereby authorize and request that payment of benefits by my Insurance Company(s) _____, be made directly to Cove Center for Recovery, LLC., herein referred to as "**Facility**", for services furnished to me or my dependent. I understand that my Insurance Company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment.

In addition, I authorize facility to disclose any and all written information from the above named to my above named Insurance Company and/or its designated representatives, or other financially responsible party, at the determination of facility. Such disclosure shall be for reimbursement purposes for those services received.

I hereby release facility its officers, agents, employees and any clinician associated with my case, from all liability that may arise as a result of disclosure of information to the above named Insurance Company(s) or their designated representatives.

By signing this Assignment of Benefits and Release of Information, I acknowledge:

- I am aware and understand that this authorization will not be used unless the above-named Insurance Company(s) or their designated representatives request records of information for reimbursement purposes; or seek to take action reference payment for treatment services.
- I agree to participate and assist facility its designated representatives with any appeal process necessary to collect payment for the services rendered.
- I am aware and have been advised of the provisions of Federal and State Statutes, rules and regulations that provide for my right to confidentiality of these records.
- I understand that this assignment and authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereof. In any event, this authorization will expire once reimbursement for services rendered is complete.
- Facility is acting in filing for insurance benefits assigned to facility and it can assume no responsibility for guaranteeing payment of any charges from the Insurance Company(s).
- Billing may be done by a firm contracted by facility for billing and collection purposes.
- Facility has been appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier.
- Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.
- Facility shall be entitled to the full amount of its charges without offset.
- I agree to endorse and forward to facility any monies from the Insurance Company paid to me and/or the primary insured. I understand that I am otherwise responsible for the cost of any and all charges accrued.

I acknowledge receipt of a completed and signed copy of this assignment and release form:

Client Signature

Legal Guardian or Insured Policyholder

Witness Signature

Date of Signatures

Cove Center for Recovery, LLC.
COORDINATION OF BENEFITS
and
PRE- EXISTING

Client Name _____

MR# _____

Date of Admission: _____

This will confirm that upon admission to Cove Center for Recovery, LLC.

I _____
(Name of Client)

(Please check all that apply)

___ Have been employed for the past eighteen months and do not have Cobra coverage;

___ Am presently unemployed, but did not work within the past eighteen months for the company identified below, but do not have Cobra coverage;

___ Am presently employed with the company identified below, but do not have any hospital/medical/health insurance coverage;

___ The only benefits available to me during my stay at Cove Center for Recovery, LLC. are through _____,
(Name of Insurance)

___ Enrolled as a dependent of _____, who is my

(Relationship)

*** I have never been treated for this condition prior to my admission to Cove Center for Recovery, LLC

(Signature of Client)

IN WITNESS WHEREOF I have here unto executed this agreement as of this ____ day of _____, 200__.

Client Signature _____

Staff Signature _____

Employer's Name and Address _____

Employer's Telephone Number _____

Cove Center for Recovery, LLC.

Client Name: _____

MR#: _____

FINANCIAL AGREEMENT

In compliance with commercial insurance regulations, arrangement for payment of co-payments and deductibles will be made at the time of admission. Please be advised that we bill your insurance company as a courtesy to you. Any remaining balances are your Responsibility.

The following constitutes the financial policy of Cove Center for Recovery, LLC, hereafter called "facility", with respect to services rendered at this facility.

1. Facility charges are an all inclusive per diem rate of \$975.00 for Day/Night Treatment and \$650.00 for Intensive Outpatient.
2. Facility will bill insurance carriers on behalf of the Client where applicable. This is a service we provide for our Clients. The Client is still responsible for all charges incurred.
3. Facility has contractual agreements with many insurance carriers. Some contracts require that we accept payment from the insurance carrier as payment in full. In such cases clients may not be responsible for Co-payments and deductibles.
4. If insurance carrier fails to remit payment for services within ninety days, the Client will be billed for the balance on the account. All statements are due in full upon receipt.
5. Facility does not provide refunds of any moneys paid by or on the behalf of Client when the Client leaves the facility against medical advice or for major rule violations.
6. If Client is transferred for therapeutic or medical reasons, any moneys paid by or on behalf of the Client will be refunded less our full per diem rate for each day Client was at our facility.
7. Initial payment for treatment is due upon admission unless insurance assignments are accepted. Subsequent payments are due on the first day of each subsequent treatment period.
8. I understand that my records are protected under Federal Confidentiality regulations (42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations) published August 10, 1987, and cannot be disclosed without my written consent unless other provided in the regulations. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, HIV/AIDS and/or related conditions.

Client Signature

Date

Witness Signature

Date

Cove Center for Recovery, LLC.
2499 Glades Road Suite 107
Boca Raton, FL 33431

INSURANCE ONLY- DURABLE POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS, this power of attorney is intended to constitute a Durable Power of Attorney under chapter 709 of the Florida Statutes, THAT I _____ (name of patient)(the "Principal"), having an address at _____ hereby make, constitute and appoint each and all of:

Cove Center for Recovery, LLC.

My true and lawful attorney-in-fact TO ACT SEVERALLY in my name, place and stead to do and perform all and every act and thing whatsoever requisite and necessary in any way which I could or might do, if personally present, with respect to obtaining payment end/ or reimbursement for hospital, medical, chemical dependency treatment and other health care services rendered to the Principal by **Cove Center for Recovery, LLC.** whose address is **2499 Glades Road Suite 107 Boca Raton, FL 33431** and any of its affiliates, including, but not limited to obtaining insurance, making of claims against insurers, or other third-party payers. Instituting and prosecuting and/or defending litigation, arbitration and/or other dispute resolution proceedings, compromise and/or statement of claims and/or disputes, obtaining and/or releasing records, reports and statements, including but not limited to any and all medical reports from prior treatment providers, subject to complying with federal confidentiality rules under 42 CFR Part 2, as well as all other acts which may be helpful and appropriate to the accomplishment of such purposes, for the ultimate objective of **Cove Center for Recovery, LLC.** collection for such services. Such additional acts shall include, without limitation, endorsing any draft, check or other negotiable instrument representing insurance or other third party benefits received by or on behalf of the Principals mailing address has temporarily changed, the filing of all documents and forms which may be necessary or appropriate to maintain, continued or extended health care insurance, including but not limited to continuation of coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), 29 U.S.C. Section 1161. Et.seq.

Each of my said attorneys shall have full and unqualified authority to my attorney(s)-in-fact to delegate any or all of the foregoing powers to any person or persons whom my attorney(s)-in-fact-shall select, to the maximum extent from time not forbidden by law. This Durable Power of Attorney shall not be affected by the subsequent disability, incapacity, or incompetence of the Principle except as provided in Section 709.08, Florida Statutes, and other specifically applicable

law.

To induce any third party to act hereunder, I agree that, as against third parties, I will not question the sufficiency of any other document executed by my attorney(s)-in-fact pursuant to this Power of Attorney. Any third party receiving a duly executed copy or facsimile of this Power of Attorney may act in reliance hereon, and that revocation or termination hereof shall be ineffective as to such third party unless and until receipt of actual notice of knowledge thereof, and I, for myself and my heirs, executors, legal representatives and assigns, agree to indemnify and hold such third party harmless from and against any and all claims that may arise by reason of reliance upon the Durable Power of Attorney. By signing this document I confirm that I have read and understand all terms of this document, which is being initiated without duress.

IN WITNESS WHEREOF, I have executed this Durable Power of Attorney on this _____ day of _____, 200__ in the presence of the witnesses signing below my signature.

STATE OF FLORIDA
COUNTY OF BROWARD

Affirmed and subscribed before me by _____ who is _____ personally known to me or has produced a _____ drivers license # _____ Identification on this _____ day of _____, 200__

PRINCIPAL Signature

Print Name

Witness Signature & Printed Name

Notary Public State of Florida at large
Notary Stamp

Notary Public Signature

Cove Center for Recovery, LLC.

Client Name: _____

MR#: _____

FINANCIAL AGREEMENT

I agree to pay Cove Center for Recovery, LLC.

\$ _____ per day, for _____

\$ _____ Total

\$ _____ Paid on Account Cash Check Credit Card

\$ _____ Balance

Payment Schedule:

\$ _____ due _____

By signing this agreement I understand that if fail to abide by the payment schedule agreed upon above, the account will be in arrears and will be turned over to a collection agency. I may also be subject to finance charges, legal fees and any other fee(s) incurred attempting to collect a debt.

Cove Center for Recovery, LLC. will **NOT** refund monies paid on account for days not completed. I understand that I am being given a discounted rate for services as I do not carry medical insurance with coverage for this service. I understand that if I leave the facility prior to completion of treatment – Against Professional Advice (APA) that Cove Center for Recovery, LLC. reserves the right to then revert that discount back to the standard fees of \$975.00 per diem for Day/Night Treatment and \$650.00 per diem for Intensive Outpatient. I will also become responsible for all ancillary charges that were included in my discounted rate.

Client Signature

Client Name

Staff Signature

Date

Dania Rexall Pharmacy- Institutional Pharmacy
Credit Card Authorization Form

FACILITY NAME: _____

PATIENT NAME: _____ **DATE:** _____

PRESCRIPTION INSURANCE CARRIER: _____

RX INS. PHONE #: _____ **PERSON CODE:** _____

POLICY ID#: _____ **GROUP ID#:** _____

CREDIT CARD HOLDERS NAME*: _____

* AS APPEARS ON CREDIT CARD

BILLING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

CREDIT CARD TYPE: (CIRCLE ONE)

AMERICAN EXPRESS **VISA** **MASTERCARD**

CREDIT CARD NUMBER: _____

EXP: _____ **SEC. CODE:** _____

I, (Credit Card Holder) _____, am the responsible party for (Patient) _____. I authorize Dania Rexall Pharmacy to apply any and all charges for the above mentioned patient to my credit card account, noted above. The charges may include, but are not limited to the following: co-payments, deductibles, over-the-counter items, medication not covered by insurance, medical equipment and supplies, or any other cash service provided by Dania Rexall Pharmacy. I understand I will receive a monthly statement listing all charges to my billing address. If patient account reaches sixty (60) days past due, patient medication will be held until account is paid. We take into account financial hardships, if you or the responsible parties are unable to render payment in full, please contact our office to discuss payment options.

Signature of Card Holder Print Name Date

Signature of Technician Print Name Date