HOPE Ranch / Katherine H. Muellner, PLLC

6005 Salem Road S.W.
Rochester, MN 55902
Telephone: (507)281-3033
Fax: (507)281-7692

Authorization to Release Information

Client's Name: _____ Date of Birth: _____/_____/_____

Authorization to Release Medical Information to Insurers: I authorize Katherine H. Muellner, LICSW, her employees or agents, to release medical information (including but not limited to information related to psychological, psychiatric, sickle cell anemia, and alcohol and drug abuse diagnosis and treatment, if such information exists) necessary for processing insurance claims to all insurers, their agents or review organizations as indicated on this form, to the Health Care Financing Administration (Medicare) or its agents.

Authorization to Release Insurance Information: I authorize Katherine H. Muellner, LICSW, her employees or agents, to contact my insurance company or health plan administrator to obtain all pertinent financial information concerning coverage and payments made under my policy with respect to services provided by her. I direct the insurance company or health plan administrator to release such information to Katherine H. Muellner, PLLC/HOPE Ranch.

Assignment of Benefits: I hereby authorize and request the insurer(s) I have listed to pay directly to Katherine H. Muellner any benefits due under the terms of this/these policy/policies for services provided by Katherine H. Muellner. I understand that Katherine H. Muellner reserves the right to refuse such assignment of medical benefits. If my health insurance will not allow direct payment to Katherine H. Muellner or if she chooses not to accept assignment of medical benefits, I agree to immediately forward to Katherine H. Muellner all health insurance payments I receive for services provided by her.

Statement of Financial Responsibility:

1. I fully understand that payment is expected at the time services are rendered unless I have made special arrangements. With these arrangements having been made, I understand that should I not comply with these arrangements, Katherine H. Muellner, PLLC/HOPE Ranch may cancel these special arrangements and the full balance, including service charges, collection and/or legal fees will be due and payable by me.
2. I acknowledge that I am responsible for all charges not paid by insurance whether I am covered by Medicare, a Health Maintenance Organization or any other third party payer.

I understand and agree that my health records may be furnished to assisting and consulting health care providers, including co-workers and employees of Katherine H. Muellner; and that financial information related to my services may be furnished to her independent accountant and business assistants and agents. I agree these provisions will remain in effect until revoked by me or for the maximum period allowed by law.

Sign Here: _____ **Date:** _____/_____/

Signature of Client or Parent/Legal Guardian if client is under 18 years of age

ATTENTION: Minnesota law requires a signed authorization from the client or a parent or legal guardian if the client is less than 18 years of age.