



15466 Los Gatos Boulevard  
Suite 109-367  
Los Gatos, CA 95032  
(800) 345-3243

## ENROLLMENT FORMS

Please fill out each of the following forms in legible handwriting:

1. **AGREEMENT AND AUTHORIZATION.** Permits Copay Solutions to act on your behalf in dealings with insurance companies, doctors and hospitals.
2. **NEW CLIENT ENROLLMENT.** Provides Copay with basic information regarding the patient and the party responsible for the Copay service.
3. **FEE SCHEDULE.** Specifies fees and payment method.

Fax back to Copay using the fax cover sheet that is included or mail back using the information at the top of this page.

## AGREEMENT / AUTHORIZATION STATEMENT

Name	
Address	
City/State/Zip	

I have engaged Copay Solutions of Los Gatos, CA ([www.copaysolutions.com](http://www.copaysolutions.com)) to assist me in managing my health insurance reimbursement. The purpose of this service is to keep records of my medical expenses, claims payments and to pursue all health insurance benefits and/or billing adjustments to which I am entitled. **This Authorization is valid until July 31, 2011.**

I grant the following authority to Copay Solutions ("Copay"):

1. To obtain diagnostic, procedural, and billing information from ANY provider of medical services or supplies. Copay may have access to my medical records, provided that Copay explains why such access is necessary. This authorization extends to any **Protected Health Information** (as defined by HIPAA), including psychiatric services.
2. To release medical and billing information to my insurance companies as Copay may deem necessary.
3. To obtain insurance eligibility, benefits and coverage information from my insurance companies. Copay is authorized to deal directly with insurance companies or intermediaries to determine and collect appropriate benefits. In this regard, Copay has authorization as power-of-attorney on my behalf.
4. To sign insurance claims forms and related documents as my custodial agent. This signature authority is strictly for the purpose of collecting health insurance benefits.

**Notice to insurance payers:** If you do not have a valid assignment of benefits, please pay benefits directly to me or Copay, as Copay is responsible for remitting to me 100% of all such amounts collected. If a claim is presented that has not been previously settled, please issue an explanation statement or letter to me or Copay.

I permit a copy of this Authorization to be used in place of the original.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Representative, state relation

# NEW CLIENT ENROLLMENT

PATIENT	RESPONSIBLE PARTY
Name	Name
Address	Address
Telephone	Telephone
Email	Email
Date of Birth	Relation
SS#	(If Responsible Party is same as Patient, indicate "Same.")

Should the PATIENT or the RESPONSIBLE PARTY be billed for the Copay service? (circle one)

INSURANCE COMPANY NAME	POLICY NUMBER

## FEE SCHEDULE

Copay Solutions requires an individual enrollment for each person using its service. Please check the appropriate enrollment type (Individual or Family) and be sure to fill-out an Authorization and a New Client Enrollment form for each enrollee. Fees are billed every two months.

√	ENROLLMENT TYPE	START-UP	MONTHLY
	Individual	\$50.00	\$50.00
	Family (up to 4 enrollees)	\$100.00	\$100.00

## PAYMENT METHOD

**CREDIT CARD.** Please enter your credit card information below.

Card Type: Visa    Mastercard    Discover    American Express  
(Circle one)

Card Number	
Expiration Date	
Security Code	
Name/address on card	

I agree to the Fee Schedule and Payment Method stated above and authorize Copay Solutions to charge my credit card for the amounts specified.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Fax

**To:** Copay Solutions

**From:**

**Fax:** (800) 647-0631

**Pages:** 5

**Phone:** (800) 345-3243

**Date:**

**Re:** New Enrollment

**CC:**

**Urgent**     **For Review**     **Please Comment**     **Please Reply**     **Please Recycle**

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Please process my new enrollment right away!