The Watershed		**Patient:**	______________________
Insurer:	______________________	**MR #:**	______________________
Account #:	______________________	**Admit Date:**	______________________

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS, THAT I, ____,
having an address at: ____
(the "Principal") hereby make, constitute and appoint: ______________________________, or, alternately, a duly authorized Billings Administrator, Case Manager, or Medical Staff Member of ____________________.

My true and lawful attorneys-in-fact TO ACT SEVERALLY in my name, place and stead and to 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 all of the following matters: (A) Insurance claims and billings, including recovery of all insurance payments, from Insurers or members, (B) Filing and appealing insurance claims, litigation, grievances and appeals, (C) Obtaining insurance plan documents, ERISA plan documents and their respective records, reports, and statements, including all medical reports and records from prior treatment providers, or former employers, the confidentiality of which is hereby knowingly waived, (D) Obtaining proof of prior credible coverage, employment and medical records and other applicable statements, invoices or receipts from current or former employers or insurance carriers, the confidentiality of which is hereby knowingly waived, (E) all acts necessary or required for the proper and complete filing of claim(s), grievances, or appeals against an Insurer or other payer, related to hospital, medical, chemical dependency treatment or rehabilitation and other health care services rendered to the Patient by____________________________________, or any of its affiliates, as well as all other additional acts helpful and appropriate in the accomplishment of such purpose for the ultimate objective of ________________'s collection of payment for such services; such additional acts may include, without limitation, endorsing any draft, check, or other negotiable instrument representing Insurer or other third party benefits received by or on behalf of the Principal, or Principal's insurance subscriber, advising an Insurer, payer, or other affiliated or appropriate party, that the Principal's mailing address has temporarily changed, and, filing of all documents, affidavits and forms which may be necessary or appropriate to maintain, continue or extend hospital/medical insurance, such as continuation coverage pursuant to applicable State Department of Insurance, ERISA or the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), rules and regulations, and (F) Obtaining on behalf of the Principal, as Principal's authorized representative, by written, verbal or electronic request, including usage of Principal's passwords, log-ins, and social security /member ID numbers, any and all employer or insurance benefit plans, including eligibility requirements, benefits, fee schedules, claim forms, COBRA forms, and all ancillary consents and authorizations, as may be promulgated by the employer or insurer whether in its original form, by hard copy, or by electronic format, and (G) Full and unqualified authority for my attorney(s)-in-fact to delegate any or all of the foregoing powers to any qualified person or persons whom my attorney(s)-in-fact shall select.

This Power of Attorney shall not be affected by the subsequent disability, incapacity, or incompetence of the Principal. I will not question the sufficiency of any document executed by my attorney(s)-in-fact pursuant to this Power of Attorney.

To induce any third party to act hereunder, I agree that any third party receiving a duly executed copy or facsimile of this Power of Attorney may act in reliance upon receipt hereof, and that revocation or termination hereof shall be ineffective as to such third party unless and until receipt of actual notice or 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 this Power of Attorney.

IN WITNESS WHEREOF, I have executed this Power of Attorney this _______ day of _______________, 201__.

____
Patient Signature

[Add Notary language for respective county/state]