Consent Agreement:

Client or Authorized Person's Signature:

- I have received a copy of the Client's Bill of Rights and the Notice of Privacy Practices.

- I consent to assessment and treatment by my clinician, who may examine my medical records, and discuss my case with the attending (or primary care) physician who may be involved in my care before or after I am examined or treated here.

- I authorize release of information to process insurance claims. I authorize the release of any medical or other information necessary to process this claim. Photocopies or reviews of relevant documents may be sent to the insurance company in order to clarify payment of benefits.

- I authorize payment to my clinician for services provided. I realize that there can be monetary limits for mental health benefits imposed by my insurance company that can involve a maximum dollar amount per year or lifetime, pre-certification, and a number of visits allowed in a time period. I agree to accept full responsibility for fees and payment once these limits have been reached.

- I hereby assign and set over to my clinician any benefits for the cost of treatment that may be entitled. I authorize the third-party payer (i.e. Insurance Company, if applicable) to make payments directly to my clinician.

- I am also aware that the insurance company may not cover certain fees that may be needed for consulting with other medical or legal professionals in regards to my care; for example, telephone consulting fees and fees for written reports. I accept full responsibility for fees and payment of fees not covered by my insurance company.

- I understand that I will be charged for appointments that I cancel without 24 hours notice and for appointments that I miss completely, and that my insurance will not cover these charges. In these cases no insurance benefits will be available. (There is a 24-hour, seven-day a week voicemail service available to leave cancellation messages).

- I understand that I am financially responsible for charges not covered by this assignment and co-payments determined by insurance carriers or payments made directly to me.

- Delinquent accounts (more than 30 days past due) will be charged interest at a rate of 1.5% per month (18% annually) unless other arrangements are made in writing.

SIGNATURE: _____ DATE: _____

If guarantor, relationship to client: _____