CONSENT FOR TREATMENT AND AUTHORIZATION TO BILL INSURANCE

Client's Name_____ DOB_____

Parent's/Guardian's Name _____

Please read <u>and initial</u> each item below, then sign at the bottom.

_____I certify that I am requesting the services of Endurance Behavioral Health for my minor child, for the purposes of mental health evaluation, recommendations, and treatment.

_____I certify that I have been advised and have received a copy of my rights to confidentiality. I understand that these rights will be respected and upheld. I understand that disclosure of information suggesting harm or the threat of harm to myself or any other person—by myself or my child—requires notification of the appropriate authorities and/or agencies as mandated by law.

_____I request payment of authorized insurance benefits or subsidies made, on my behalf, payable to Endurance Behavioral Health for any services provided to me. I authorize any holder to release to my insurance company medical information about me needed to determine benefits or the benefits payable for related services, regulatory compliance, state audit or quality assurance purposes.

_____I understand that Endurance Behavioral Health will submit my insurance claims and that I will be responsible for any deductible, co-payments, co-insurance or client fees at the time services are rendered. I understand that I will receive a monthly statement if my account has a balance due. I understand that Endurance Behavioral Health cannot accept responsibility for collection of my insurance claim or for negotiating a settlement on a disputed claim and that I am responsible for payment of my account.

_____I understand that there is a 24-hour cancellation policy and if I fail to appear for a scheduled appointment, I will be responsible for payment.

_____I understand that my services and/or treatment with Endurance Behavioral Health may be terminated in the case of non-compliance. This includes non-adherence to the Program Agreement, instructions regarding prescribed medications, and treatment plans; repeatedly missing appointments; or failure to pay the fees for services rendered and determined as obligatory by my insurance and the guidelines of this practice.

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Signature Date