FINANCIAL RESPONSIBILITY

I understand that Affiliates in Behavioral Health LLC expects payment in full at the time of the appointment unless preauthorization for treatment has been obtained before the appointment. If the patient is my child, I understand that the parent accompanying the child to the appointment is responsible for payment at the time of service. I understand that my insurance company will only pay for services that are medically necessary and for which I have obtained preauthorization. **Since insurance companies do not pay for missed appointments, I understand that I will be personally liable for payment of any missed appointments not canceled with at least 24 hours notice.** Accounts overdue for sixty days may be turned over to an external collection service. In the event of non-payment of charges, I agree to pay all costs of collection, including reasonable attorney fees. If for any reason the insurance company denies payment for the treatment rendered, I understand that I am personally and fully responsible for payment of these services. I will also be responsible for deductibles, copayments, collection fees or missed appointment fees. I authorize Affiliates in Behavioral Health LLC to release all information needed to secure payment of my or my child's account. I understand that Affiliates in Behavioral Health LLC will cooperate with my insurance company to assure that my insurance company helps to pay for treatment. However, I understand that I am ultimately responsible for obtaining authorization for care and for ensuring that the insurance company is making timely payments.

Signature of Patient/Guardian ____________________ Date

CONSENT FOR TREATMENT and COORDINATION OF CARE

I give permission for clinicians at Affiliates in Behavioral Health LLC to evaluate, coordinate and treat me or my child (for whom I am legal custodian). I further authorize any tests, procedures and medication as deemed necessary and mutually agreed to by me. To facilitate coordination of care, I authorize the release of medically necessary information to other treating clinicians at Affiliates in Behavioral Health LLC as well as to the patient's PRIMARY PHYSICIAN____________________
whose office is located at____________________

Signature of Patient/Guardian ____________________ Date

MEDICARE PATIENTS ONLY

I request that payment of authorize Medicare benefits be made on my behalf to Affiliates in Behavioral Health LLC for any services furnished to my children or me. I authorize any holder of medical information about me to release my medical information to the Center for Medicare and Medicaid Services or its agents in order to determine benefits payable for related services. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If the appropriate items of the HCFA-1500 claim form are completed, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, I will be responsible for the amount remaining between Medicare's payment and the Medicare allowed charge, any deductible, co-insurance, copayments and non-covered services. Co-insurance, copayments and deductibles are based upon the charge determination of my particular Medicare carrier.

Signature of Patient/Guardian ____________________ Date