LIKEMIND

Mental Health & Wellness, Inc.

CONSENT FOR TREATMENT & AUTHORIZATION TO BILL INSURANCE

Client's Name_____ DOB_____

Parent's/Guardian's Name _____

Please read and initial each item below, then sign at the bottom.

_____I certify that I am requesting the services of LIKEMIND Mental Health & Wellness, Inc. for myself or 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 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 LIKEMIND Mental Health & Wellness, Inc. for any services provided to me or my child. 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 LIKEMIND Mental Health & Wellness, Inc. 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 if I am unable to pay the amount due at the time of my scheduled appointment, I will be charged a late cancellation fee and my appointment will be rescheduled. I understand that LIKEMIND Mental Health & Wellness, Inc. 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 I am responsible for immediately informing LIKEMIND Mental Health & Wellness, Inc. of any change to my insurance coverage. In the event that I do not, I will be responsible for payment of any charges incurred that are no longer billable to my prior insurance.

_____I understand that my services and/or treatment with LIKEMIND Mental Health & Wellness, Inc. may be terminated in the case of non-compliance. This includes non-adherence to the treatment recommendations and plans and instructions regarding prescribed medications; 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.

HEALTH INSURANCE INFORMATION

Primary Insurance Company:_____

ID Policy #: _____

Group #:_____

Policy holder's Name: _____

Date of Birth: _____/_____/_____

Employer/School

Patient Relationship to Insured: Drop Down (Self, Spouse, Child, Other)

Person Responsible for Account: Drop Down (Patient, Parent, Other)

Name (if different from patient)

Date of Birth: ____/_____/_____

Phone # _____-_____-_____

_____ _____

Patient or Parent/Guardian Signature Date

_____ _____

Witness Signature Date