

COMMUNITY MENTAL HEALTH CENTER OF CRAWFORD COUNTY

Consent for Treatment and Agreement to Pay

Client Name: _____ **Date:** _____

★ Medicaid Number: _____ Effective Date: _____

★ Medicare Number: _____ Effective Date: _____

★ Insurance Carrier: _____ Effective Date: _____

Policy Number: _____

Group Number: _____

Insurance Carrier Billing Address: _____

Policyholder Name: _____ **Policyholder Birthdate:** _____

Policyholder Address: _____

Relationship to Consumer: _____

If insurance if through an employer, Name of Employer: _____

Policyholder Signature: _____

Copy of Insurance Card, Medicaid Card, or Medicare Card Attached:

★ Private Pay:

Income: \$ _____ Number of Dependents: _____ Fee: \$90/ _____

The usual, customary rate is \$90 per hour, however you may be eligible for a fee reduction based upon your income. Depending on your insurance coverage, your insurance may cover some or all of your fee. You will be responsible for the portion not covered by your insurance.

The minimum discounted rate for Doctors and ARNPs is \$20. The minimum discounted rate for other services is \$10 per hour. All fee reduction requests will be negotiated/reviewed on an individual basis.

I agree that the above information is substantially correct and agree to pay the fee stated above.

I understand that a cancellation not made prior to appointment time will cause a \$10 charge to be billed against me for the time scheduled.

I am applying and consenting to evaluation and/or treatment at the Community Mental Health Center of Crawford County. This may include use of standard medical, psychiatric, psychological, and social work procedures deemed necessary for diagnosis and treatment

I also authorize the Community Mental Health Center of Crawford County to disclose to my insurance carrier stated above information needed for billing purposes, which may include, but is not limited to treatment dates, diagnosis, and therapist. This authorization, unless expressly revoked earlier, expires upon the closing of my file at the Community Mental Health Center of Crawford County.

I authorize payment of insurance benefits directly to the Community Mental Health Center of Crawford County for services rendered.

Signature of Consumer or Legal Guardian

Date

Signature of Witness

Date