INTEGRATED
BEHAVIORAL
HEALTH
psychological services

CONSENT FOR TREATMENT

Patient Name: _____ DOB: _____

___ Yes ___ No I have received a copy of the Patient Information Form and Privacy Practices Form.

___ Yes ___ No I authorize the release of any medical information necessary to process my insurance claims.

___ Yes ___ No I understand that I will be held financially responsible if the insurance information provided is incorrect or no longer valid.

___ Yes ___ No I authorize benefits to be paid directly to IBH Psychological Services.

___ Yes ___ No I acknowledge that I may be personally charged **$50** for appointments not canceled at least 24 hours in advance other than for emergency reasons.

___ Yes ___ No I consent to the exchange of treatment information between IBH Psychological Services and my (or my child's) primary care provider.

Primary Care Provider:_____Phone:_____

___ Yes ___ No I acknowledge that I have read and understand all of the forgoing statements and that my signature below indicates that I agree to abide by all of the above.

Patient Signature:_____Date:_____

If patient is **under 18 years of age**, (or over 18 years of age and has a legal guardian):

Parent/Legal Guardian Signature:_____ Date:_____

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