Authorization for Treatment & Payment of Medical Benefits
Patient Financial Responsibility Form

Thank you for choosing Calm4Kids Therapy Center, LLC as your behavioral healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality behavioral healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment, and patient financial policies.

Authorization for Treatment & Payment of Medical Benefits

I give permission to the practice, Calm4Kids Therapy Center, LLC, to provide behavioral healthcare services for diagnosis and treatment. I authorize the release of patient information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice, Calm4Kids Therapy Center, LLC.

Patient Financial Responsibilities

I (or patient's guardian, if a minor) understand that I am ultimately responsible for the payment of my treatment and care. You will assist me by billing your contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.

I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, and most major credit cards.

I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include (but are not limited to):
Charge for returned checks.
Charge for missed appointments.
Charge for phone consultations with myself or with others (teachers, doctors etc.), if consultation was requested by me and lasts longer than 15 minutes.

Patient Authorizations

By my signature below, I hereby authorize the practice, Calm4Kids Therapy Center, LLC, to release medical and other information to the necessary insurance companies and third party payers required for payment of rendered health services.

By my signature below, I hereby authorize assignment of financial benefits directly to the practice, Calm4Kids Therapy Center, LLC. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

I have read, understand, and agree to the provisions of this Authorization for Treatment & Payment of Medical Benefits and Patient Financial Responsibility Form:

Signature of Patient or Guardian:____
Date:_________________