Balance Behavioral Health PLLC
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BALANCE BEHAVIORAL HEALTH, PLLC
SIGNATURE AUTHORIZATION FORM

Provider Services Agreement (Please Initial)

_____ I have reviewed a copy of the PROVIDER/PATIENT SERVICES AGREEMENT and a copy of the PRIVACY NOTICE.

Release of Information (Please Initial by Each Item)

_____ I hereby authorize BALANCE BEHAVIORAL HEALTH, PLLC to furnish to the insurance company(s) or to a designated attorney, all Protected Health Information which insurance company or attorney requests.

_____ I hereby authorize BALANCE BEHAVIORAL HEALTH, PLLC to use Protected Health Information with colleagues for the purpose of Treatment/Consultation.

I understand that BALANCE BEHAVIORAL HEALTH, PLLC may share information as necessary with my primary care physician. Please indicate your desire about BALANCE BEHAVIORAL HEALTH, PLLC sharing information with your primary care physician: (Please note that some insurance companies refuse coverage without this authorization)

_____ NO – I do not give permission to share information with my physician

_____ YES – I do give permission to share information with my physician

Assignment of Benefits and Financial Responsibility (Please Initial by Each Item)

_____ I understand that payment is due at the time of service unless other arrangements have been made and I agree to pay my co-payment/deductible at the time of service.

_____ I understand that BALANCE BEHAVIORAL HEALTH, PLLC will file my insurance claim on my behalf and I thereby assign to BALANCE BEHAVIORAL HEALTH, PLLC all money to which I am entitled for the counseling services rendered by professionals associated with this practice.

_____ I agree it is my responsibility to advise BALANCE BEHAVIORAL HEALTH, PLLC of any insurance changes prior to any appointment.

_____ If I have agreed to a discounted out-of-pocket rate, I will not file claims with my insurance company either now or in the future unless I provide updated information to BALANCE BEHAVIORAL HEALTH, PLLC and they check my benefits.

_____ I hereby agree that I am financially responsible for all non-covered charges and I acknowledge it is my responsibility for all charges denied due to my not notifying BALANCE BEHAVIORAL HEALTH, PLLC of any insurance changes until after services were rendered.

_____ I agree that in the event of non-payment, to bear the cost of collections and/or court cost and legal fees should this be required.

I have read, understand, and accept all of the provisions of the Provider/Patient Services Agreement and the responsibilities identified above and consent to treatment.

Printed Name of Patient or Responsible Party: _____ Today's Date: _____/_____/_____

Date of Birth of Patient or Responsible Party: _____/_____/_____ Social Security #: _____-_____-_____

Signature of Patient or Responsible Party: _____