CONSENT FOR TREATMENT OR EVALUATION SERVICES

I hereby authorize Cyndie Ford Purdy, LMHC, to provide treatment and/or evaluation services. Payment of fees and the insurance procedures have been explained to me. I agree to pay fees at the time services are rendered. Should it become necessary to refer this account to an attorney or collection agency, I agree to pay all reasonable collection costs. **I understand the charges I incur at the office of Cyndie Ford Purdy, LMHC are my responsibility and that my insurance is billed as a courtesy**.

_____ _____
Client Signature Date

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to client: _____

Date of Birth: _____Social Security #: _____

Do you have medical insurance? _____ Yes _____ No **If yes**:

Name of Primary Insurance Company: _____

Contract #:_____Group #:_____

Subscriber Name and Address:_____

_____

Subscriber #:_____Subscriber's Date of Birth:_____

Please mark the programs you are covered under:

_____Medicare _____Medicaid _____Champus _____ChampVa _____Worker's Compensation

ID# for program you checked above: _____

NOTE: This provider is unable to accept Medicare or Medicaid. Any charges incurred at this office by a Medicare or Medicaid participant are the participant's full responsibility. We do not file claims for either of these two insurance companies. If you have any questions about our insurance coverage please speak with the office manager or call the customer service department of your insurance carrier. **You are responsible for any charges not covered by insurance**. **Your signature on this form acknowledges that you are aware of your financial responsibility and agree to these terms.**

ASSIGNMENT AND RELEASE OF INFORMATION

I hereby authorize Cyndie Ford Purdy, LMHC, to release to_____
(Name of Insurance Company)
information about my diagnosis and/or documentation of treatment for the purpose of reimbursement. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I assign directly to Cyndie Ford Purdy, LMHC any and all medical benefits, otherwise payable to me, for services rendered. **I understand that I am financially responsible for all charges whether or not they are covered by insurance.**

_____ _____
Client Signature Date

☐ Copy given to client ☐ Copy refused by client Revised 03.19.13