AUTHORIZATION AND CONSENT

Please initial each line item and sign and date below

_____I authorize the providers at Child & Adolescent Specialty Care (CASC) to render treatment deemed necessary in his/her professional opinion. I will make every effort to comply with the recommended course of treatment.

_____I understand that payment is due at the time service is rendered. I understand that copays are due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize the authorization allows CASC to view my pharmacy benefits when available from my insurance company.

_____I authorize and direct my insurers to pay directly to CASC and/or its physicians any and all benefits up to the amount of my bill pertaining to all charges incurred. I assign to CASC, including its affiliates, any and all benefits or proceeds, of any type whatsoever, to which I am entitled, with respect to the health care service(s) I receive, including but not limited to, the proceeds of any liability settlement or judgment being paid by or on behalf of a third-party and any benefits due from any third-party insurance policy. I direct that all such benefits be paid directly to CASC and/or its affiliates, including its physicians, and applied to my account(s) until the account(s) is paid in full. I understand that I am personally responsible for any remaining fees. I hereby agree to pay all costs and reasonable fees in the event this account is turned over for collections. I authorize CASC to contact me on any phone number provided by me for the purposes of conducting business with me or contacting me concerning my account. I understand that I am financially responsible to CASC for all charges not covered, approved or considered necessary by my insurance company. I will pay at the time of service or will establish an agreeable payment arrangement with the billing department.

_____I attest that the health insurance information and card that I presented today is the most current health insurance to which my child is entitled to receive benefits. I understand that should this health insurance be terminated and not the current health insurance, it is my responsibility to contact CASC within 30 days of the date of service to provide current health insurance information. In the even I do not provide the most current health insurance, I understand and agree that I will be financially responsible for the entire charges of services that were submitted to the incorrect insurance company or filed past the "timely filing" as a result if my providing inaccurate health insurance information.

_____I understand that in the even my child's health insurance changes in any way, i.e., Company, benefits, copays, it is my responsibility to contact CASC and provide this information. I agree that I will be responsible for any and all charges incurred through my failure to provide a change to my child's health insurance information.

Signature: _____ Date: _____

Signature: _____ Date: _____

Responsible Party Signature (if different than patient)