CONSENT FOR TREATMENT

I give my permission to _____ to provide outpatient mental health services to my child or myself. I am aware that my provider is available to answer any questions about my treatment or this form. If treatment is for a minor, I affirm that I have the legal right to seek non-emergency mental health treatment for my child. If at any time I should lose the right to seek care for my child, I will inform the treatment provider as soon as possible, prior to any further treatment occurring.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize the Greater Baltimore Counseling Center, LLC (GBCC) staff to apply for benefits on my behalf. I authorize payment directly to the Greater Baltimore Counseling Center, LLC for psychological benefits.

PATIENT NAME _____ PATIENT'S BIRTH DATE_____

SUBSCRIBER'S NAME_____ INSURANCE ID/GROUP #_____

INSURANCE COMPANY NAME_____

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information to my insurance carrier for the purposes of processing my claim. I also permit a copy of this authorization to be used in place of the original and it may be retained on file. If my insurance company or coverage changes in any way, it is up to me to inform GBCC of these changes, and to obtain pre-authorization necessary for my continued care.

I agree to take full responsibility for the fee for services rendered. Co-payments are due at the time of each visit. The initial evaluation is billed at $200.00. Subsequent 60 minute sessions are billed at $175.00 and 45 minute sessions are billed at $140.00 for therapy. Follow up visits for the Nurse Practitioner are billed at $100-$150 depending on the type of follow up care received. I understand that I am responsible for any portion of the fee not covered by insurance such as:

1. **Yearly deductible if not met**
2. **Missed or canceled appointments (unless I provide at least 24 hours notice)**
3. **Benefits used to their maximum in a calendar year or lifetime**
4. **Co-payments**

The fee for missed appointments for all of our services is $100.00. A $25.00 fee will be charged for returned checks. I also agree to be responsible for reimbursement of the total professional fee plus costs that may arise from having GBCC staff to retain a collection agency, lawyer or court presentation to collect delinquent fees. I acknowledge that if I have a credit card on file, I may be charged the final amount due on my account up upon termination of treatment.

If I become involved in court proceedings that require provider's time, I will be expected to pay for professional services in advance at a rate of $250.00 per hour. Services related to court proceedings include, but are not limited to: report writing, telephone calls, court/deposition appearances and travel time.

I acknowledge that the Notice of Privacy Practices has been made available to me.

_____ _____

Patient or Parent/Guardian Signature Date

_____

Print Name

_____ _____

Witness Date