Patient Acct. # _____

Patient Name _____

Child Psychiatry Associates, P.C.

Read Carefully and Sign Name Below

Authorization To Release Medical Information: I authorize release of medical information necessary to process insurance claims, including physical, mental, HIV, drug or alcohol use history.

Authorization To Assign Medical Benefits: I assign all medical benefits and major medical benefits to include private insurance and other health plans to Child Psychiatry Associates, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am responsible for payment of all medical services regardless of insurance coverage.

Acknowledgement Of Payment Responsibility: Co-Payments are due at the time of service. If you need a payment plan, please tell us immediately so our Billing Department can help you make arrangements. If you share co-payments for your child's care because of divorce, you must pay at the time of service and arrange for coordination of reimbursement on your own.

Pre-Authorization: Mental Health and Chemical Dependency services WILL NOT BE PAID without prior authorization **if required** by your insurance company. Please check this information on the back of your insurance card. Check with our receptionist if you need help with obtaining authorizations.

Please sign below to indicate your authorization of above.

Signature of Patient or Guardian_____ Date_____

This Clinic accepts Visa, Mastercard, personal checks and cash.
Co-payments are due at time of service.

I have had the opportunity to review the HIPAA "Notice of Privacy Practices".
_____ (Initial)