Fields Behavioral Health
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Consent to Treatment and Payment

I, _____, acknowledge that I have had all my questions about treatment answered fully and to my satisfaction.

I seek and consent to take part in treatment with the Provider named below. I understand that developing a treatment plan with this Provider and regularly reviewing our work toward meeting the treatment goals are in my best interest. I understand and agree to play an active role in the treatment processes. I understand that failure to actively participate in treatment is grounds for dismissal as a patient of this practice, without liability to Fields Behavioral Health.

I understand that no promises have been made to me about the results of treatment or of any procedures provided by Fields Behavioral Health.

I am aware that I may stop my treatment with this Provider at any time. If I do, I will have to pay for the services I have already received. I understand that I may lose other benefits or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 72 hours (3 business days) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment. I agree to pay a no-show fee of $100 per missed appointment. I understand that this is not covered by my insurance. I understand that treatment will be suspended until this fee is paid, and release Fields Behavioral Health from any liability related to this break in treatment.

I am aware that my health insurance company or other third-party payer may be given information about my diagnose(s) and life functioning, as well as the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the Provider will stop my treatment.

I am aware that I am responsible for all copays at the time of the appointment, however Fields Behavioral Health reserves the right to bill for this payment after the appointment. I understand that not all treatment is covered by my insurance. Should I agree to treatment not covered by my insurance (this would be discussed prior to that treatment), I am responsible for paying for this treatment out of pocket. All bills for services must be paid within 30 days of mailing.

I agree that non-payment for services (i.e. having an outstanding balance that the patient is responsible for), will be treated as the patient (you) voluntarily discontinuing care, and Fields Behavioral Health will not be held liable for that voluntary discontinuation of care. I further agree to the release of billing information to any and all parties involved in the recovery of such outstanding balance, to include collection agencies.

My signature below shows that I understand and agree with all of these statements.

_____	_____	____/____/____
Signature of client or legal representative	Printed name	Date

_____	_____
Printed name of legal representative	Relationship to client

I, the Provider, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____	____/____/____
Signature of Provider	Date

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.