Patient's Name _____ DOB _____

Payment Policy, Financial Acknowledgement, and Insurance Assignment

The client is responsible for costs of services provided. This may include the client, the client spouse, or the client's parent or legal guardian.

The Caring Trees policy is to pursue of the collection of all monies due the facility from third-party sources, the client, or any other responsible party. Clients are considered delinquent after 90 days from the date of service. Failure to make payments monthly or to make an appropriate payment arrangement will induce collection efforts. If collection efforts are unsuccessful the account will be turned over to a collection agency there after all services provided may be on a cash only basis.

The Caring Tree will make every attempt to collect from your insurance company. Please check your insurance policy or discuss your coverage with your employer or insurance agent. The Caring Tree accepts MasterCard and Visa for payment of services.

Medical assistance covers most outpatient services. Clients will be required to pay their copayment at the time of their payment. If you have questions, please call The Caring Tree at 715-301-0667.

I request and authorize The Caring Tree Children's Counseling Center to release to:

Insurance Company Name:

_____

information from my records necessary to pre-certify/authorize services and process my claim for insurance benefits, Medicaid payment, for services provided by The Caring Tree. This includes mental health, alcohol/drug, developmental or other medical diagnoses, discharge summary's and clinical notes to include physicians orders, treatment plans (where required), and test results. The purpose of this authorization is to enable the recipient to pre-certify/authorize and process my claim. I understand I have the right to inspect and receive a copy of this form and the material to be disclosed as required under SS. HFS 92. 05 and 92. 06. This consent is given voluntarily and I understand that treatment services are not contingent upon my decision concerning this release of information. I may revoke this concerns at any time except to the extent that action has been taken in reliance on it (45 CFR 164. 508 (c)(2)(I). This consent unless expressly revoked earlier is valid for one year from signature date.

I authorize and request payment directly to The Caring Tree children's counseling center of all benefits otherwise payable to me for services provided by The Caring Tree, not exceeding its regular charges. I understand that, as a patient, I am financially responsible for all charges regardless of whether paid by the insurer. This assignment cannot be revoked without the written consent of The Caring Tree.

Also, if needed to initiate or facilitate enrollment/recertification in the medical assistance program, I authorize The Caring Tree to contact and share information with the county department of social services.

Client or Parent/Legal Guardian Signature _____ Date _____

Witness Signature _____ Date _____