

**Consent To Treat and Agreement of Payment**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand that my clinical services here will be paid by:

(Client’s Name)

Self-Pay or Co-Pay at rate of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per session.

**And/Or**

(Circle one):

1. Billed to my Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Payed by My EAP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Payed by the Turning Point/Tree House Fund\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Payed by a different Third Party \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I agree to provide payment of fee for service or copay at the time service is rendered. I also agree to abide by the requirements and responsibilities of my insurance (if applicable). I understand that I am responsible to any deductible or unpaid amounts that my insurance (if applicable) does not cover.

By signing here, I agree to the payment arrangement as indicated above and consent to treatment with Union Family Services on behalf of myself or my child in accordance with Client Rights and Responsibilities as indicated. I understand that included in consent is the permission to seek emergency medical care from a hospital or physician. I am aware that a minor may seek and receive periodic services from a physician without parental consent in accordance with General Statute 90-21.5. I am aware that no consent for use of restrictive intervention was obtained as this agency does not utilize any planned or unplanned restrictive interventions.

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Staff Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_

**By Initialing here, I attest that I was offered a copy of this signed form \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Ufslf041816**