Agape Youth Behavioral Health

Authorization & Informed Consent

If you are not the legal guardian, a signed consent form is required from the custodial parent. If you are divorced, a copy of the divorce papers stating your legal guardianship is required prior to treatment.

I agree and consent to participate in the behavioral health care services offered and provided by Agape Youth Behavioral Health. I understand that I am consenting and agreeing only to those services that my provider qualified to provide within the scope of the provider's license, certification, and training.

I authorize Agape Youth Behavioral Health to release to my insurance company, managed care organization, state agency (ies), Health Care Financing Administration, third party administrators, and/or Worker's Compensation or its agents any information needed to process my claim and/or determine benefits payable to related services. I also authorize Agape Youth Behavioral Health to utilize a fax machine to transmit and/or all of the above medical records pertaining to my medical care of insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of medical records.

I grant permission for Agape Youth Behavioral Health to release all or part of my medical records to any consulting entity that may be involved in my medical care. This includes, but is not limited to the purposes of treatment, payment, and healthcare operations.

I request that payment of Medicare, Medigap, Traveler's Railroad Retirement, Managed Care Organizations, Third Party Administrators, Commercial, Worker's Compensation, Liability, and/or any other insurance benefits be made on my behalf to Agape Youth Behavioral Health for services furnished to me or on my behalf by that provider.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Fee Agreement & Waiver

Please Initial:

_____It is your obligation to stay current with your bill. Payment is due at the time services are provided. Future appointments will not be scheduled until your account is current. Please discuss any problems you may have with making payments as well as any changes in your financial situation.

_____ It is your responsibility to notify your provider 24 hours in advance if you are unable to keep your scheduled appointment. If you do not notify your provider, you may be billed for that session. Insurance carriers will not cover missed appointments, therefore, that portion of the bill would be your responsibility.

_____If insurance coverage is available, we will file for insurance reimbursement. This service is a courtesy we extend to our patients, not a requirement. Please provide the necessary information. Failure to do so will require full payment from guarantor on the account. You are also responsible for any deductibles or co-payments at the time of service.

_____ I understand that I am financially responsible for the deductible amount, co-payments, co-insurance amounts, non-covered charges and any and all balances not covered under a contractual write-off agreement between Agape Youth Behavioral Health and my third party payer. My carrier's failure to pay does not release me from this responsibility. I also agree that should this account be turned over to collection, I will be responsible for all costs associated with debt collection, including attorney fees and court costs. I acknowledge the receipt of Agape Youth Behavioral Health Notice of Privacy Practices. I understand that questions or complaints should be directed to the privacy office.

_____ I understand that it is my responsibility to obtain a referral from my primary care physician, if required, and contact my insurance prior to my visit to receive information about the pre-authorization. Insurance companies will not backdate an authorization; therefor, if this step is omitted or forgotten, you are held liable.

_____ If my insurance plan has changed, it is my responsibility to notify the office prior to my appointment. In instances where my plan required pre-authorization or a referral from my primary care physician, it is my responsibility to notify the physician's office. If I do not give proper notification prior to the visit, and insurance denies a claim, I understand the bill is my obligation. This applies to all insurances.

_____We cannot resubmit claims for dates incurred before notification of an insurance change due to guidelines for timely filing.

FORM MUST BE FILLED OUT COMPLETELY IN ORDER TO RECEIVE TREATMENT

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