5815 Broadway ♦ Great Bend, KS 67530
800-875-2544 ♦ 620-792-2544 ♦ 620-792-7052 (fax)

SIGNATURE FORM

CONSUMER INFORMATION			
Last Name:	First Name:	Birth date:	SSN:

PLEASE READ AND INITIAL THE FOLLOWING STATEMENTS BEFORE SIGNING.

( ) I have received a copy and understand The Center for Counseling & Consultation's Fee Policy and Client Rights. I understand that Proof of Income must be provided to receive reduced fees.

( ) I have received a copy and understand The Center for Counseling & Consultation's Notice of Information Practices & Notice of Treatment Non Discrimination.

( ) I allow the coordination of care between The Center for Counseling & Consultation and my Primary Care Physician.

( ) Assignment of Insurance Benefits: In the event the client/responsible party or the undersigned is entitled to benefits arising out of any insurance policy covering the client, those benefits are hereby assigned to THE CENTER for application toward the clients account. I authorize the release of any medical information necessary to process the claim and request payment of insurance benefits. I understand that I am financially responsible for any charges not covered by insurance.

(IF THIS FORM IS BEING COMPLETED BY A REPRESENTATIVE OF THE CLIENT)
PLEASE INITIAL AND PRINT THE NAME OF THE CLIENT RECEIVING SERVICES BELOW.

( ) I am requesting services for ______________________________

Additionally, The Center may need to contact the client to provide appointment information. The client may request limitations to such contact in a written request. I approve The Center to use the following forms of communication regarding my appointment information:

❑ Text Message ❑ Email ______________________ ❑ Voicemail

X

Date | Signature of Client/Responsible Party/Guardian

X

Date | Witness