Consent to Treatment / Financial Responsibility / Authorization to Release Medical Information / Assignment of Benefits

I, _____ , consent to treatment to be rendered to
(Patient or Responsible Party- please print)
me, my dependent, or other person designated below, and, in so doing, agree to be responsible for the payment of professional fees**. Such fees or supplemental charges, may include, but are not limited to patient copays, deductibles, non-insured services (ie., prescription renewals outside your appointment time, pharmacy authorizations, telephone/email communications, document preparation, hospital admission coordination), or services deemed by my insurance company or its agents as medically unnecessary**. **In the event that my insurance coverage cannot be verified prior to service delivery, I agree that I will be responsible for payment in full. I further agree that I am responsible, as a supplemental charge, for payment of the full billed amount of charges not paid by my insurance company or its agent within 45 days from the date of their receipt of a claim. (In accordance with The Texas Insurance Code and Department Rules, Articles 3.70-3C, Section 3A and 20 A.18B and in the Texas Administrative Code Sections 21.2801 - 21.815. An interest rate of 6% per annum may be imposed on amounts commencing on the 60th day from the date of service. A fee of $60.00 is charged for missed appointments, unless canceled 24 hours in advance. The office does not file out of network claims, but will provide a statement for you to file. Full payment for those covered by a non-network plan is due at the time of service.**

I authorize Pleasant Care Behavioral Health Services, Inc., or those acting in its behalf, to provide information regarding my medical, psychiatric, or substance abuse treatment to my insurance company or its agents for the purpose of determining benefit eligibility, for certification of care, or for claims processing purposes. This authorization is valid until revoked in writing by me or by my legal guardian. By signing this document, I represent Pleasant Care Behavioral Health Services, Inc. and its employees that I have in force, and am entitled to, the benefits of any applicable health plan which I have presented. I hold Texas Behavioral Health Systems, PA and its employees harmless for any damages resultant from denial of payment, lack of certification, lack of payment for medically-recommended treatment, or failure on the part of my insurance company or its agents to maintain confidentiality in regard to my condition.

I assign any insurance benefits to Pleasant Care Behavioral Health Services, Inc.

_____ _____
Patient (Recipient of Care) (Please Print) Date

_____
Signature

_____ _____
Responsible Party (if other than patient) (Please Print) Date

Signature of Responsible Party_____

We require a credit or debit card for services not covered by insurance:

*Unpaid balances for services rendered **including those listed above**, may be charged to the following Credit or Debit Card* [ ] MC [ ] VISA [ ] AMEX [ ] DISC

Card No. _____Exp. Date _____

Cardholder Name_____
(Please Print)

Cardholder Signature_____

PLEASANT CARE
BEHAVIORAL HEALTH

_____ _____

SIGNATURE OF PATIENT Date