Name:_____

KN Mental Health Services
11111 Hall Road
Utica, MI 48317
586-697-0218

AUTHORIZATION FOR TREATMENT AND BILLING

FEE SCHEDULE: Regular Session (38-52 minutes)--$120 per session
Extended Session/Intake (53-68 minutes)--$190 per session
Shorter Session (30-45 minutes) $90
Payment is due at the time service is provided

THIRD PARTY PAYMENT:

I authorize direct payments of any third party insurance benefits for services rendered. If the third party payment benefits are not paid directly to you or are paid in an amount which is less than the agreed upon charge, or insurer refuses to acknowledge the obligation for the payment of charges for services rendered, I acknowledge my personal responsibility and agree to pay the amount of any charges for which we have not been paid through third party insurance benefits. I am aware that it is then my choice and my responsibility to seek resolution of any dispute with my insurer.

I acknowledge that I have been informed and am aware of charges for services rendered and agree to pay or authorize the third party insurer to pay those rates or their contracted portion.

In the event that the client is a minor, I represent that I have the right and authority to authorize treatment and hereby authorize you to provide services to that minor.

NO SHOW AGREEMENT

There is a charge for scheduled appointments that are not kept or that are canceled less than 24 hours before the appointment time, (other than for emergencies). I understand and acknowledge that I am personally responsible for this charge and that it is not covered by any third party insurance benefits. For a no-show, or late cancellation, I agree to pay $50.00. ____

CANCELLATIONS

I understand that multiple cancellations and no shows will result in termination of my case.

Signature of Responsible Party _____ Date _____

Signature of Witness _____ Date _____

Name:_____