INTEGRAL HEALTH ASSOCIATES

437 Orange Street, New Haven, CT 06511 Tel (203) 909-6370, Fax (203) 909-6374, Alt Fax (203) 777-6776

PATIENT AUTHORIZATION FORM

AGREEMENT TO RECEIVE TREATMENT

I, (name of patient) _____, agree and consent to participate in behavioral health care services offered and provided by Integral Health Associates.*

_____ _____

Signature of patient, parent, or legal guardian* Date

*If the patient is under the age of 18 or is unable to consent to treatment, I attest that I have legal custody of this individual and/or am legally authorized to initiate and consent to treatment on behalf of this individual. I hereby consent for this individual to participate in behavioral health care services offered and provided by Integral Health Associates.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been shown or given a copy of the Notice of Privacy Practices of Integral Health Associates. This form is posted in our waiting room and included in our downloadable and mailed New Patient Patient Packet.

_____ _____

Signature of patient, parent, or legal guardian Date

FINANCIAL RESPONSIBILITY

I hereby agree to pay all charges for services provided by Integral Health Associates for the treatment of (name of patient)_____. I agree to be personally responsible for such charges, including any fees associated for late cancellations, missed appointments, and late payments, including interest charges. Furthermore, I agree that if my account defaults because of my failure to pay the balance due, I will be financially responsible for the cost of payment collection, including collections agency and/or attorney fees and court costs permitted by law.

_____ _____

Signature of financially responsible party Date

RELEASE OF INFORMATION FOR INSURANCE PROCESSING

I hereby authorize Integral Health Associates to release medical information about me to my insurance company or managed care company for the purpose of documenting medical necessity and appropriateness of treatment, and for processing insurance claims.

_____ _____

Signature of patient or authorized person Date

AUTHORIZATION OF PAYMENT OF MEDICAL BENEFITS

I hereby authorize my insurance company or managed care company to pay my health insurance benefits directly to Integral Health Associates for any treatment provided.

_____ _____

Signature of patient or authorized person Date