INTEGRAL HEALTH ASSOCIATES

# PATIENT AUTHORIZATION FORM

## AGREEMENT TO RECEIVE TREATMENT

I, (name of patient) _____, consent to participate in behavioral health care services offered and provided by Integral Health Associates. I have read the "Other Information, Policies, Terms, and Conditions" document and understand and accept the contents therein. This document is included in our online and mailed New Patient Packet, and available on our website (www.integralhealthct.com).

_____ _____
Signature of patient or legal guardian* Date

*If the patient is under the age of 18 or is unable to consent to treatment, I, (name of legal guardian) _____, 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.

## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read, been shown, or given a copy of the Notice of Privacy Practices of Integral Health Associates. This notice is posted in our waiting rooms, included in our online and mailed New Patient Packet, and available on our website (www.integralhealthct.com).

_____ _____
Signature of patient 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, late payments, interest charges, and billable paperwork. Furthermore, I agree that if my account defaults because of my failure to pay the balance due, I will be financially responsible for compensating Integral Health Associates 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 legal guardian 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 legal guardian Date