Marc Weisburg, LPCMH, CAADC

CONSENT TO TREAT

Client Name: _____Date of Birth: _____

Mailing Address:

_____

_____

_____

Phone: Home: _____Cell: _____Work: _____

E-mail Address: _____

Marital Status: Single Married Domestic Partner Separated Divorced Widowed

Check Appropriate Pay Source

I authorize my insurance to pay MarcWeisburg for any covered benefits.

_____Insurance Plan: _____

ID # _____ Group #: _____DOB: _____

Employer: _____

I hereby request and consent to the performance of treatment and recommendations offered by this office where as consistent with the fundamentals of the treating practitioners credentials. I understand that a treatment plan with recommendations will be offered and my consent is given for all related treatment.

I understand that if I do not have coverage for which Marc Weisburg is a provider, I am responsible for the fee in full for any services provided to by Marc Weisburg. I understand Marc Weisburg does not enforce court orders regarding payment arrangements, child support or other orders related to services.

I understand that it is my responsibility to provide any new information regarding my residence or pay source as soon as possible.

_____ _____ _____

Client Signature Witness Date

FINANCIAL POLICY

INSURANCE: You have insurance that covers Mental Health care: we will bill your insurance directly. The billing department will verify your insurance. Our Main concern is your health and wellbeing, and we will do our best to help you.

FEES: Our fees are available at your request**.**

I understand that my treatment will be billed to my Insurance Company for services rendered.

Client Signature _____ Date _____