CHILD AND FAMILY THERAPY ASSOCIATES
1121 WESTRAC DRIVE S, SUITE 204
FARGO, ND 58103
T: 701.893.3419 F: 701.356.8801

CONSENT FOR CARE AND TREATMENT (INCLUDING MINOR)

I, _____ give my consent to treat:

myself OR minor child _____
Circle one

date of birth _____, by a psychologist/psychology resident/therapist/nurse practitioner at Child and Family Therapy Associates. I consent to any treatment considered necessary and proper in treating my/his/her mental condition. I acknowledge that I am responsible for all charges in connection with any care and treatment rendered. I understand that this consent can be terminated at my request.

_____ _____
Signature of parent, legal guardian, or patient Date

_____ _____
Witness Date

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby authorize Carita R. Shawchuck, Ph.D. PC, and Child and Family Therapy Associates to file a claim to my insurance carrier and/or the Social Security Administration and its carriers, and payment to be made directly to them. I certify that I have the same insurance as stated on the registration form.

I authorize release of any medical information necessary to process the claims.

I agree to notify Child and Family Therapy Associates as soon as I am aware of any changes in my health condition or health plan coverage.

I understand that I am responsible for charges not covered by my insurance. I understand that I must have a balance due of zero prior to continuous sessions or testing unless prior formal alternative payment arrangements have been made.

I authorize the release of mental health information to my primary care/referring physician and to other healthcare providers to whom I may be referred for evaluation and treatment. I can revoke my release of medical information at any time.

_____ _____
Signature of parent or legal guardian Date

_____ _____
Witness Date