CONSENT TO TREAT, RELEASE/OBTAIN INFORMATION
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY

COURAGE CENTER

_____ _____
Client name *Date of Birth*

I give my consent for Courage Center to provide treatment.

X _____ (initial)

I authorize Courage Center to release and obtain verbal, written and electronic health information about the above-named client from health care providers involved in the medical treatment and management of the client's medical care.

Name of physician	***Clinic name***	***Clinic address***

Name	***Organization***	***Address***

I authorize release of all health information except: _____

I understand that these records are protected under federal and state laws and regulations and cannot be disclosed without my written consent unless otherwise provided by law.

I understand that this authorization will be in effect for a period of one (1) year following the date of signature. I may revoke or amend this consent only by written notice to Courage Center.

X _____ (initial)

I authorize Courage Center to release any information from the client's medical records to Medical Assistance, Medicare, other governmental payers, private health insurance companies or plans, or organizations acting on their behalf, as may be necessary to determine benefits and process claims.

I authorize _____ to assign the amount payable under the client's contract directly to Courage Center. I understand that I am financially responsible for all charges that are not covered by the client's private insurance company. I also understand that I am responsible for knowing the benefits covered under the client's private insurance plan.
(name of insurance company)

I understand that I am responsible for notifying Courage Center if there is a change in the client's insurance coverage or funding status.

I acknowledge that co-payment is due and payable on the date the client receives the service.

I have been given a copy of Courage Center's Financial Policy. **X** _____ (initial)

I have been given a copy of Courage Center's Notice of Privacy Practices. **X** _____ (initial)

The following persons may not receive information about the client:

_____ _____
Name *Relationship*

_____ _____
Name *Relationship*

X _____ _____
Signature of client or client's representative *Date*

X _____ _____
Print name of client's representative *Relationship*

Email address (optional & confidential) _____