STATEMENT OF CONSENT and AGREEMENT TO ENTER TREATMENT

A. I, the undersigned, agree and consent to participate in the mental health services offered and provided by the Samaritan Center, mental health provider, as defined in Indiana law.
B. I understand that I am consenting and agreeing only to those mental health services that the provider is qualified to provide within:
    (1) the scope of the provider's license, certification, and training; or
    (2) the scope of license, certification, and training of those mental health providers directly supervising the services received by the client.
C. I hereby authorize my insurance benefits to be paid directly to The Samaritan Center, realizing that I am responsible to pay any non-covered services.
D. I hereby authorize the release of pertinent medical information as requested by my insurance carriers.
E. I understand that the Samaritan Center may employ a collection agency or an attorney in the collection of overdue accounts.

I have read and agree to the policy and consent statements:

_____
Clients Name (Print)

_____ _____
Client Signature or (Guardian for minors) Date

CLIENT INSURANCE INFORMATION

To file insurance, we require a copy of your insurance card.

Would you like the Samaritan Center to file insurance for you? ____Yes____No

Client's Name_____ Client's Date of Birth _____

Insurance Company Name_____

Name of Insured, if not the client_____ Insured's DOB_____

Address of Insured if different from Client_____

_____Phone number of Insured _____

Insured's ID # _____ Insured's Group #_____

Place of Employment _____

Client's Relationship to Insured ___Self ___Spouse ___Child