Better Life PARTNERS

CONSENT FOR TREATMENT AND AUTHORIZATION TO BILL INSURANCE

Client's Name: _____ Date of Birth: _____

Please read and initial each item below, then sign at the bottom.

_____ I certify that I am requesting the services of Better Life Partners Inc. for myself, for the purpose of substance use disorder treatment, including screening, assessment, evaluation, diagnosis, and treatment.

_____ I certify that I have been advised and have received a copy of my rights to confidentiality. I understand these rights will be respected and upheld. I understand that disclosure of information suggesting harm or threat of harm to myself or any other person requires notification of the appropriate authorities and/or agencies as mandated by applicable law.

_____ I request direct payment of authorized insurance (including Medicare, Medicaid, or Medicare Supplemental) benefits or subsidies made, on my behalf, payable to Better Life Partners Inc. for any and all services provided to me. I authorize any holder to release to my insurance company medical information about me needed to determine benefits or benefits payable for related services, regulatory compliance, state audit or quality assurance purposes.

_____ I understand that Better Life Partners Inc. will submit my insurance claims and that I will be responsible for any deductible, co-payments, co-insurance or client fees at the time services are rendered. I understand that I will receive a monthly statement if my account has a balance due. I understand that Better Life Partners cannot accept responsibility for collection of my insurance claim or for negotiating a settlement of a disputed claim and that I am responsible for payment of my account.

_____ I understand that my services and/or treatment with Better Life Partners may be terminated in the case of non-compliance. This includes: non-adherence to the Treatment Agreement, instructions regarding prescribed medication, and treatment plans; repeatedly missing appointments; or failure to pay the fees for the services rendered and determined as obligatory by my insurance and the guidelines of this practice.

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

This document may contain protected health information, which is captured pursuant to an authorization or as permitted by law. The information herein is confidential intended only for use by the designated recipient who/which must maintain its confidentiality and security. If you are not the designated recipient, you are strictly prohibited from disclosing, copying, distributing, or taking action in reliance on the contents hereof. If you have received this document in error, please notify the sender immediately and arrange for the return or destruction of all its contents. Unauthorized redisclosure of confidential health information is prohibited by state and federal law.