**Consent for Mental Health Evaluation and/or Treatment**

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I voluntarily consent that my child (listed above) will participate in a mental health evaluation and/or treatment from Infinity Wellness Center LLC. I understand that developing a treatment plan with the therapist and regularly reviewing our work toward meeting goals are in my best interest. I agree to pay an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by the therapist. I am aware that I may stop my treatment with this therapist at any time. The only thing I will be responsible for is payment of the services I have already received.

This agreement shows my commitment to pay for services from Infinity Wellness Center LLC. The price range for some services is listed below. The actual charged amount will depend on the services provided, complexity of service, provider type and other factors.

1. Initial Clinical Interview (Diagnostic Evaluation 90791)

2. Individual (90837) and family therapy (90846 or 90847)

3. Testing and other therapy prices vary based on individual need and will be discussed prior to or at the time of service.

**Insurance Coverage:** I agree to pay for services rendered at the end of each session. Insurance may cover part or all of the cost of treatment, however, I understand that it is my responsibility to look into my coverage and be knowledgeable about my benefits. I also understand that there may be some types of treatment that may not be covered by insurance but may be clinically recommended by my therapist. My therapist will provide an estimated cost to me for such services before they are rendered. If I am not a member of Blue Cross Blue Shield, I understand that I am responsible for payment in full at the time of service and any outstanding balance not paid at the time of service may be charged to my credit card.

**Blue Cross Blue Shield Plans:** I understand that Infinity Wellness Center LLC is only in network with BCBS Traditional and PPO plans for mental health. If I am a member of one of these plans, Infinity Wellness Center LLC will file my claims and receive reimbursement according to the coverage certificate specific for my plan and will be responsible for any copay, coinsurance, deductible, or any charges not covered by my plan. I understand my insurance policy is a contract between me and my insurance plan, therefore any charges not covered by my insurance plan are my responsibility.

**Changes to Client Information**: I understand it is my responsibility to notify Infinity Wellness Center LLC of any changes to my insurance coverage, including all insurance plans that my child is listed under. I also understand that it is my responsibility to notify Infinity Wellness Center LLC of changes to all other information, including but not limited to: address, phone number, responsible payer, etc. Any service charges that are not covered by insurance as a result of inaccurate information on my insurance plan will be my responsibility.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (parent/guardian of the above stated child) have read and understand the above statements and consent to evaluation/ treatment of my child. I understand that I have the right to ask questions of my child’s services provider about the above information at any time.

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