AGREEMENT TO CONDITIONS
OF PSYCHOLOGICAL EVALUATION OR TREATMENT

Julie Evans Bingham, Ph.D. **Clinical Psychologist**

Patient Name:_____

MEDICAL CONSENT: I wish for myself to have a clinical, psychological and/or neuropsychological evaluation by Dr. Bingham. If appropriate and available I also wish for myself to become a patient of Dr. Bingham. I authorize Dr. Bingham or any other psychologist authorized by her to provide such psychological or neuropsychological services, either regular or emergency, as may be determined to be in the best interest of myself who is under her care. This authorization shall continue and be in full force and effect for one calendar year or until revoked in writing by me.

I have read the above and fully understand it, and have asked questions about anything not clear to me, and am satisfied with the answers I have received. I am the patient's parent, legal guardian, or the adult patient or I am authorized to consent on behalf of the patient.

_____	_____	_____
Date	Parent, Legal Guardian, Adult Patient	Witness
_____	_____	
Date	Adolescent Patient's Assent or Consent	

AUTHORIZATION TO RELEASE INFORMATION TO INSURER: I authorize Dr. Bingham to release from my psychological records any information required by my insurance carrier or any person, corporation, or agency responsible for managing the care or processing of my claims for medical and mental health benefits. I understand that if an insurance company or government agency is paying for my medical or mental health care, they may have access to sensitive information about my diagnosis and treatment. This authorization is valid for the life of the claim.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize payment directly to Dr. Bingham of all insurance or health plan benefits otherwise payable to me, to the extent of the patient's bill.

FINANCIAL AGREEMENT: I agree to pay Dr. Bingham for services provided to me. **I understand I am financially responsible for charges not covered by my insurance or other agency. I understand I am responsible for any deductible and coinsurance payments.** All accounts are payable in full at the time of billing; a courtesy period of 30 days is given. If after 60 days the insurance payment is not received, the balance in full becomes my responsibility. If my account becomes past due, I may be required to pay interest on the unpaid balance. If this account is placed in the hands of an attorney or collection agency, I will pay reasonable attorney's fees and collection costs, whether or not a suit is filed.

I certify that I have read the above, including the financial agreement, and fully understand it. I am the patient's parent, legal guardian, or the adult patient or I am authorized to execute and accept the terms of this agreement on behalf of the patient. I assume individually all financial responsibility by noting my signature below.

_____	_____
Date	Parent, Legal Guardian, Adult Patient Person Assuming Financial Responsibility

PDF created with pdfFactory Pro trial version www.pdffactory.com