Lehigh Psychological Services
5920 Hamilton Blvd. Suite 103
Allentown, PA 18106
(610) 395-5188

Consent to Treatment and Agreement to Pay for Professional Services

I (or my minor child/legal dependent) do hereby seek and consent to take part in treatment with Lehigh Psychological Services. If services are for a minor or legal dependent, I attest that I am fully authorized to seek treatment on his/her behalf under all custodial agreements.

I acknowledge that I have received and have read the "Information for Clients" provided to me. I understand that no promises have been made to me regarding the results of treatment or of any procedures provided by psychologists or psychotherapists.

This agreement acknowledges my commitment to pay Lehigh Psychological Services for therapy and/or evaluation services provided to me, or my dependent. I agree to pay for appointments that I do not cancel or those where I fail to give 24 hours' notice that I will not attend, according to the "Appointment Cancellation Policy" provided to me and any/all collection agency fees (33.33%), attorney fees and/or court costs if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Pennsylvania and any other state.
I am aware that I may stop my treatment at any time.

I understand that all payments, including co-payments, are due at the time of service. I understand that for and in consideration of services rendered by Lehigh Psychological Services to me, my minor child, or legal dependent, I guarantee payment of all charges incurred in accordance with the policy of payment of such bills. I understand that Lehigh Psychological Services is *not* responsible for mediating payment disputes with my insurer(s) and that I am fully responsible for any fees my insurer(s) does not pay.

If I receive psychological testing/evaluation services, I understand that I will be billed for the clinical hours the tests are administered, and for the hours required to score the tests, analyze data, and prepare a final report. Test results will not be released until my balance is paid in full.

My signature below indicates that I request payment of the authorized Medicare and/or insurer benefits be made on my behalf to Lehigh Psychological Services for services provided. I understand that this is a lifetime authorization for Lehigh Psychological Services to submit claims on my behalf for outpatient services. I understand that I may revoke the authorization of assignment at any time.

I certify that the information given by me in applying for payment of services is correct. I agree to immediately notify Lehigh Psychological Services if this information changes. I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and provider(s) of any services or treatments I receive. Medicare regulations may apply.

I agree, in order for Lehigh Psychological Services to service my account or to collect monies I may owe, Lehigh Psychological Services and/or their agent may contact me by telephone at any telephone number associated with my account, which I understand could result in charges to me. Lehigh Psychological Services and /or their agents may contact me by sending text messages or emails, using any email address I have provided them. I acknowledge methods of contact may include using prerecorded/artificial voice messages and/or the use of automatic dialing devices, as applicable. A photocopy of this assignment is to be considered as good as the original.

____ ___________ ____

Client's Name-Please Print | Date of Birth | Parent's/Guardian's Name- Please print

Relationship to Client, (ie: Parent)_____________________

___________________________________ Date__________

Client's signature (14 and older)
Indicating agreement to all statements above

____

Parent's/Guardian's Signature Date
Indicating agreement to all statements above

Forms/consent to treatment and payment agreement.msw 09/2016