HEALTHY MINDS
Psychiatric Services

Okemos Location: *2390 Woodlake Drive, Suite 380; Okemos, MI 48864* P: 517-333-7113 F: 517-333-7125
Brighton Location: *4763 South Old US 23, Suite C1; Brighton MI 48114* P: 810-775-3534 F: 810-775-3549

Insurance Release/ Consent

Patient's Full Legal Name:	**Date of Birth:**
*(If patient is a **minor,** please print full legal name of parent/guardian(s) signing on behalf of the patient.)*	
Print Full Legal Name:	Relationship To Client:
Print Full Legal Name:	Relationship To Client:

Insurance Billing

I authorize Healthy Minds to release any medical information to their billing company for paper & electronic billing to my insurance company. I permit a copy of this authorization to be used in place of the original. I authorize my insurance company to assign benefits to Healthy Minds. I understand that I am responsible for payment of services rendered by Healthy Minds, regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by insurance company. I certify that I am responsible for all services not paid by insurance. This authorization is valid indefinitely until revoked by myself or the physician by written request. I agree to notify Healthy Minds immediately whenever I have changes in my health plan coverage.

Account Responsibility

I am responsible for payment to Healthy Minds for all services rendered, due at time of the visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. If I default on any payment obligations as called for in this agreement, Healthy Minds reserves the right to forward my information to collections, and an additional 30% may be assessed to my account to cover the costs of this action. There will be no obligation to provide continuing services to any client who names Healthy Minds as a creditor in any bankruptcy filing.

Informed Consent

I am consenting to treatment and have received and understand the contents of the Office Policies.
My signature below indicates that I fully understand and agree to all of the terms and conditions of the Policies. If I have questions, the information has been explained and/or summarized for me.

SIGNATURE(S) (PATIENT OR LEGAL GUARDIAN)	**DATE:**
SIGNATURE(S) (PATIENT OR LEGAL GUARDIAN)	**DATE:**

Healthy Minds Witness Signature　　　　Date

Rev: 03/28/2018