

DOREEN HUTTON, LPC

3311 81st Street, Suite K
Lubbock, Texas 79423
(806) 239-3376

AUTHORIZATION AND AGREEMENT FOR TREATMENT

The undersigned hereby makes the following Acknowledgments and Agreements regarding treatment to be provided to the patient whose name appears below.

1. **Consent to Treatment.** I understand that medical treatment is necessary, and that such medical treatment and procedures will be performed by independent physicians, and by the employees of the Practice. I hereby grant my authorization and consent for such treatment and procedures.
2. **Agreement to Pay for Services.** I acknowledge and accept that no guarantee has been given as to the results these treatments may produce in me. I further acknowledge and accept that any treatment(s) given may not help me and may make my condition worse. For and in consideration of the care and treatment provided to the patient, I promise to pay, or arrange for payment, **AT THE TIME OF THIS VISIT** all charges due for services rendered to or on behalf of the patient. Payment may be made by cash, check or credit card. Legal action to collect money from insufficient fund checks or stop payment checks; will be at the patient's expense. In the event your account is turned over to a collection agency, a 35% fee will be added to the balance. Any fees associated with the collection of a past due balance will be the responsibility of the patient.
3. **Assignment and Instruction for Direct Payment to Doctor.** I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

**Doreen Hutton, LPC
P.O. Box 54136
Lubbock, Texas 79453**

If my current policy prohibits direct payment to medical practitioners, then I also instruct and direct you to make out the check to me and mail it directly to:

**Doreen Hutton, LPC
P.O. Box 54136
Lubbock, Texas 79453**

For the professional and medical benefits and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE POLICY.** This payment will not exceed my indebtedness to the above named assignee(s).

Also, I have agreed to pay, in a current manner, the balance due of any and all professional and medical service charges over and above any insurance payment. I understand that **I am fully financially responsible for all these charges at all times.**

4. **Release of Medical Information.** I authorize the release of any and all information pertinent to my case to any insurance company, adjuster, or attorney involved in this case who makes the request in writing. Further, I authorize the release of my medical information to my personal or referral physician.
5. **Risks.** Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of any medical, and/or diagnostic procedures planned for me. I realize that common to a medical, and/or diagnostic procedure is the potential for infection, allergic reactions, failure of treatment, and even death.
6. **Cancellation Charge.** A \$25.00 fee will be charged to the patient for all appointments not cancelled 24 hours prior to the appointment. Insurance companies including Medicare will not pay for this charge; therefore the patient will be 100% responsible for the fee. In the event you fail to cancel 2 (two) appointments you will be dismissed from the practice.

I have read the above Acknowledgments and Agreements, and fully undersigned and agree to them.

Dated at the _____ **Office of Doreen Hutton, LPC** _____ This _____ day of _____, 20_____.

Patient Signature _____ Witness Signature _____

Policyholder Signature, if other than Patient _____

A photocopy of this form shall be conceded as acceptable and valid as the original.