LIFE in BALANCE
COUNSELING & WELLNESS CENTER
Enriching Mind, Body & Spirit

JOINT TREATMENT CONSENT WHEN CUSTODY REQUIRES

BOTH PARENTS'/GUARDIANS' PERMISSION

Child's Name ______________________ DOB ______________________

Please provide information and signatures for BOTH PARENTS and/or GUARDIANS below.

AUTHORIZATION

We both authorize treatment deemed necessary by Life in Balance Counseling & Wellness Center Practitioners. We both authorize Life in Balance Counseling & Wellness to release to our health plan(s) any and all information which is deemed necessary regarding the care and treatment of our minor child above to insure prompt payment of all charges for services provided. We hereby assign the payment for all insurance benefits to Life in Balance Counseling & Wellness for any and all charges incurred in connection with services provided to our minor child. We also consent to a copy of this authorization and assignment being used in place of the original.

We understand fully that we both remain responsible to pay Life in Balance Counseling & Wellness Center for all charges not paid by either my insurance companies and/or employer, subject to the rules of any federal or state health insurance program such as Medicaid, or to other contractual provisions that may limit a patient's responsibility to pay for medical costs and services. Payment shall be due at the time of the appointment or within thirty days of receipt of a statement.

Parent #1 Name ______________________________ Phone # ___________________

Address ____________________________ City __________ State ______Zip ________

Signature ____ Date __________________

Parent #2 Name ______________________________ Phone # ___________________

Address ____________________________ City __________ State ______Zip ________

Signature ____ Date __________________