The Stern Center
for Developmental and Behavioral Health

CONSENT TO TREATMENT

I, _____ am an adult or a minor at least 14 years old consent and agree to comply with my role in treatment and authorize The Stern Center to provide

- ❑ Intake assessments,
- ❑ Psychological evaluation
- ❑ Psychiatric evaluation and medication management
- ❑ Therapeutic counseling
- ❑ IBHS services
- ❑ FBMHS services
- ❑ Telehealth

The current insurance is _____

Insurance number _____

I do not have any additional insurance (initial) _____

I understand that The Stern Center for Developmental and Behavioral Health, Inc. will bill my medical assistance plan and/or commercial insurance that I have for these services, and I give my consent to authorize the release of pertinent medical information to insurance carriers for such billing. **I understand that I am obligated to pay co-payments and deductibles as required by my insurance. I understand I am finically responsible for all non -covered services. I also understand that I will be financially responsible for all treatment fees if I fail to keep the Stern Center informed of changes in my insurance.**

I understand that all payments are due at the time of service. If the Stern Center sends a bill for services rendered, there will be an additional $15.00 fee charged per occurrence.

The Stern Center can refuse, suspend or cancel all future appointments if I fail to keep my account up to date.

Communication between the client and the Stern Center staff is privileged and confidential. The privacy of your health care information is regulated by the Pennsylvania Bureau of Professional and Occupational Affairs and the Health Insurance Portability and Accountability Act (HIPAA). The specifics are described in the Notice of Privacy Practices posted in our office and available to you at the time you sign this form.

I have read this document and understand the above information.

- ❑ I am the client, an adult or a minor 14 years of age, and I am consenting to my own treatment
- ❑ I am the parent/guardian of the minor client and I consent for the minor's treatment
- ❑ We are choosing to both consent and sign

_____ _____
Client Signature Date

_____ _____
Parent or Guardian Signature Date

☐ *Verbal//Telehealth Consent*