# **AUTHORIZATIONS**

1. Authorization for Treatment

   I authorize treatment and give permission for Dayspring, Center for Christian Counseling to develop a treatment plan and provide treatment.

   ______________________________ ____________
   Signature Date

2. Insurance Information and Payment

   If you wish to have our office file your insurance, please present card. Some companies pay fixed allowances for treatment and others pay a percentage of the charge. It is your responsibility to pay for any deductible amount, co-pay, any non-covered, or service for which you are ineligible. Authorization of service and payment by the insurance company's contingent of eligibility (at time of service) and benefits available. It is your responsibility to pay co-pays at each visit. I hereby authorize release of information necessary to file a claim with my insurance company or other third party willing to pay for my services and assign benefits directly to the therapist or group indicated on the claim. **I understand I am financially responsible for any balance not covered by my insurance.**

   ______________________________ ____________
   Signature Date

3. Failed Appointments

   I agree to notify Dayspring Center for Christian Counseling at least twenty-four (24) hours prior to my scheduled appointment if I decide to cancel. I understand I will be charged for an appointment not kept or not canceled at least 24 hours in advance. **I also understand that this charge is not reimbursed by my insurance.**

   ______________________________ ____________
   Signature Date