CandiCares, PLLC

Client Authorization

Client _____ Date of Birth (DOB) _____

Insurance ID# or SS# _____

Request for **Outpatient Psychotherapy** Services

I voluntarily consent to and request the above service of CandiCares, PLLC and that payment of authorized insurance benefits is made on my behalf to CandiCares, PLLC. I authorize holder of medical information about me to release to my insurance company or to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related service. I understand that my insurance company may assign a portion of the bill as client responsibility/liability which I will make restitution. My responsible party (financial agent) may also be informed that I am receiving services for billing purposes unless I request otherwise. I authorize the release of information to my attending Physician, when applicable, and upon my further approval via a signed Authorization to Release Information document. I understand that I have the right to revoke this authorization/request for services at any time.

_____ _____

Client or Legal Guardian Signature HCPOA, if applicable

_____ _____

Client or Legal Guardian Printed Name HCPOA Printed Name

_____ _____

Witness Signature Date

_____

Witness Printed Name

****

NOTE: Sign here ONLY if client is unable to sign this form.

Client consents to treatment but is unable to sign acknowledgment forms due to: _____

_____

_____ _____

Witness Signature Date

(Only when client is unable to sign this document)

Copy(ies) of insurance cards is/are required.

Revised 9/15/2015