Justin Cline, LCSW

913 SW Higgins Ave.

Suite 104 B

Missoula, MT 59803

406-370-2379

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize assignment of benefits for services rendered by provider, Justin Cline. Initials:\_\_\_\_\_\_\_\_\_\_\_

I, ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize assighment of benefits for services rendered by provider, Justin Cline. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Justin Cline to share information with regards to my treatment, progress, and recommendations with my insurance company. It has been explained to me that information shared may be given over the phone, through written reports and/or faxed to my insurance coverage. Initials:\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand the cancellation policy of giving 24 hours in advance notice and will agree to pay the full fee for the session missed to Justin Cline if I fail to honor this policy. I have also been apprised that my insurance coverage does not pay for this. Initials:\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to pay the co-payment fee of \_\_\_\_\_\_\_\_\_ at the time of my office visit. Initials:\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that though my health insurance company authorized treatment for my outpatient mental health services, this is no guarantee that they will approve payment of service. My insurance company claims they have the right to make that determination following submission of the claim even if my provider has met all the regulations in so far as submission of claims in a timely manner and outpatient reports which are required to be completed in order for me to receive continued services. If they should deny payment for my visits, I understand that I am responsible for payment of cost to the provider according the contracted rate of the provider. Initials:\_\_\_\_\_\_\_\_\_\_\_

I have read and understand the above policies and had any questions about them answered.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_