PATIENT: _____

AUTHORIZATION AND RELEASE

AUTHORIZATION FOR TREATMENT: I authorize treatment of the patient named above

_____

Signature(s) Relationship to Patient Date

AUTHORIZATION FOR TREATMENT: (For ages 14 to 17) I authorize treatment of the patient named above:

_____

Signature Witness if declined Date

AUTHORIZATION TO CONFIRM OR CORRESPOND (Optional): I hereby authorize Riegler, Shienvold and Associates to contact me at home / work to confirm my appointments and to send periodic correspondences to my home.

_____

Signature Relationship to Patient Date

_____

Signature of Pt. (for ages 14 to 17 who have signed above) Date

THE FOLLOWING ASSIGNMENT AND RELEASE MUST BE COMPLETED AND SIGNED IF YOU WOULD LIKE US TO BILL YOUR INSURANCE — INCLUDING HMO'S

ASSIGNMENT AND RELEASE: I, the undersigned, certify that I (or my dependent) have

insurance coverage with: _____

and/or their designated mental health managed care company and assign directly to Riegler, Shienvold and Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I hereby authorize Riegler, Shienvold and Associates to release all information necessary to obtain authorizations and/or secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Signature of responsible party Relationship to Patient Date

_____

Signature of patient (for ages 14 to 17) Date

Note: For patients ages 14 to 17, their signature establishes consent to release information to the insurance company for reimbursement purposes.

Rev. 5/12