

I understand that I am responsible for all co-pays, deductibles and balances that are not paid by my insurance. Billing to insurance will be provided as a courtesy. I will be responsible for the payment of any missed appointment that is not cancelled 24 hours prior to the time services were to be rendered. _____ (initial here).

I hereby assign, transfer, and set over to Daniele & Associates all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of my medical information needed to determine these benefits. This authorization shall remain valid until written notice is given revoking said authorization. I understand that I am financially responsible for all charges whether or not covered by insurance.

Patient/Guarantor Signature

Date

Have you ever had mental health treatment before?	Yes	No
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If "yes," what were you treated for?

Is there a family history of:		
Alcoholism	Anxiety	Bi-polar Disorder
Depression	Drug Abuse	Eating Disorders
Self injury	Divorce	Schizophrenia
Other (explain):		

Signature of Client

Date

Signature of Parent/Guardian

Date