NEW OAKLAND FAMILY CENTERS

face to face

AUTHORIZATION FOR COMMUNICATION AND BILLING

Consumer Name: _____ DOB: _____ Age: _____

In relation to services provided by New Oakland Family Centers to _____ **(Consumer)**

I, _____ **(Responsible Party)** agree to the following terms and conditions:

1. I understand that payment for services is due at the time services are rendered.
2. I authorize direct payment of any third-party insurance benefits to New Oakland Family Centers for services provided to the above-named consumer. If the third-party insurance benefits are not paid directly or are paid in an amount which is less than the agreed upon charge, I acknowledge my responsibility and agree to pay the amount of any charges that have not been paid through third party insurance benefits.
3. I authorize the release of information required to obtain reimbursement for services or to obtain benefits for which I may be eligible.
4. I acknowledge that I have been informed and am aware of charges for services rendered and agree to pay or authorize third-party insurers to pay those rates or their contracted portion.
5. In case my insurer refuses to acknowledge the obligation for the payment of charges for services rendered, I agree to be responsible for and to pay the charges for those services. I am aware that it is then my choice and my responsibility to seek resolution of any dispute with my insurer.
6. In addition to charges established for professional services, New Oakland Family Centers may charge for the performance of certain administrative work requested. This includes, but is not limited to, medical records requests, completion of sick leave authorization, completion of disability forms, etc.
7. If the above-named consumer is a minor, I represent that I have the right and authority to authorize treatment and authorize New Oakland Family Centers to provide services to that minor and to bill on their behalf.

By completing this form, I also consent to receive text messages/emails related to New Oakland services (e.g., appointment reminders) and understand that I may be contacted by phone, mail and/or email regarding any billing issues that occur.

CONSENT FOR TREATMENT/RECIPIENT RIGHTS

I consent to and voluntarily seek treatment at New Oakland Family Centers or, iIf the consumer is a minor, I represent that I have the right and authority to authorize treatment and authorize that services be provided to that minor. I also acknowledge that I have reviewed and accept the Recipient Rights provisions of this consent available online at www.newoakland.org/recipientrights. During the COVID-19 emergency, I permit the use of this is abbreviated version of the full treatment/recipient rights consent found online at www.newoakland.org/intakeforms. I further acknowledge I will complete and provide to New Oakland the full consent packet when circumstances permit.

CONSENT FOR TELEHEALTH SERVICES DURING COVID-19 EMERGENCY

I acknowledge I (or the minor for whom I am the Responsible Party) will be receiving therapy services remotely via teleconference during the COVID-19 precautionary period. I also accept there may be potential exceptions to full HIPAA privacy compliance during my teleconference sessions.

_____	_____	_____	_____
Signature of responsible party	Date	Signature of clinic staff	Date