*****CONFIDENTIAL******

Center for Assessment, Inc.
26711 Woodward Avenue, Suite 301
Huntington Woods , MI 48070
(248) 677-0074 * Fax (248) 677-0089

Consent to Bill Insurance Company

I, the undersigned, authorize the above named therapist's office to submit claims to my insurance company. If it is the case that my insurance company utilizes a managed care company, my therapist may need to discuss my treatment with a case manager. I understand that my confidentiality will be compromised in such a case. I realize that his/her doing so is a necessity in his effort to secure ongoing care. I also authorize payment of medical benefits to the above named therapist for services provided.

I understand that ultimately I am responsible for all payment relating to any and all charges relating to treatment and services that I have received at Center for Assessment, Inc. during my care. I also understand that my insurance company and related policy plan may offer benefits for services provided at Center for Assessment, Inc., but that such benefits do not necessarily guarantee payment for those services.

_____ _____
Patient Name (please print) Date

_____ _____
Patient Signature Date

_____ _____
Insured Signature Date
(If Different than Patient)

_____ _____
Parent/Guardian Signature Date