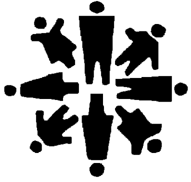

Catholic Counseling Services, Inc.

499 St. Matthews Street • El Paso, TX 79907
Ph.(915) 872-8424 • Fax (915) 872-8425

CONSENT FOR TREATMENT / CLIENT RIGHTS AND RESPONSIBILITIES

MENTAL HEALTH SERVICES	I consent for Catholic Counseling Services, Inc. to provide me/my marriage/my family with mental health services, which may include the following: evaluation, counseling and referral to other appropriate resources.
CONTACT WITH PRIMARY PHYSICIAN	I authorize Catholic Counseling Services, Inc. to contact my primary care physician in order to request and/or provide information regarding my treatment.
THIRD PARTY COVERAGE	I authorize any funding source, governmental agency, or private insurer to review my records for the purpose of determining if I received the services which were billed on my behalf.
EMERGENCY AFTER HOURS	If you experience an emergency, please contact the El Paso Psychiatric Center at 532-2202.
PATIENT'S OR AUTHORIZED PERSON'S CONSENT	I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of Government benefits either to me or to Catholic Counseling Services Inc. who accept assignment.
INSURED'S OR AUTHORIZED PERSON'S CONSENT	I authorize payment of medical benefits to Catholic Counseling Services Inc. for services provided.
BANKRUPTCY	I authorize Catholic Counseling Services, Inc. to contact the court/and my attorney in case I should file for bankruptcy.
CLIENT RIGHTS AND RESPONSIBILITIES	I have read and understood Catholic Counseling Services, Inc.'s statement on Client Rights and Responsibilities.

A FEE WILL BE CHARGED FOR ALL LATE CANCELLATIONS AND NO SHOW APPOINTMENTS THAT ARE NOT MADE WITHIN 24 HOUR ADVANCE NOTICE.

I understand that if I fail to sign this form, Catholic Counseling Services, Inc. will not be able to provide services to me.

Client Signature____ Date:__________________

Spouse's Signature____Date:__________________

Parent/Guardian ____ Date: _________________

Witness:____ Date:__________________