Authorization for Mental Health Treatment

Mental Health Treatment: I hereby authorize and consent to any services deemed necessary in connection with the above-named patient, but not limited to, diagnostic procedures, testing or therapeutic services, and any other services which are deemed necessary or advisable by the clinician and rendered to the patient under the general or special instructions of said clinician.

Signed _____
Date _____

Payment Authorization: I authorize Dr. Dean Kirschner/Life Mastery Center to bill and accept payments directly for insurance benefits otherwise payable to me, but not to exceed the balance due of the regular charges for this or subsequent periods of treatment. I understand that I am financially responsible to Dr. Dean Kirschner/Life Mastery Center for charges not covered by third-party or insurance payments, any co-payments or deductibles, and for personal charges.

I understand that I am responsible for informing Dr. Dean Kirschner/Life Mastery Center of any changes in my insurance status, coverage or eligibility for benefits.

If a Medicare beneficiary, the treatment is covered by Medicare for all or a portion of the charges. This treatment is subject to a review by another organization to determine coverage and appropriateness of care. I have received information about my rights and responsibilities in reference to the mental health services, the coverage, and the general process for the review and/or appeal.

I authorize the release of any information from Dr. Dean Kirschner/Life Mastery Center as required by my insurance company or any other reimbursing agency.

Signed _____
Date _____

HIPPA Acknowledgement:

I acknowledge that I received the Notice of Privacy Practices from Dr. Dean Kirschner/Life Mastery Center

Signed _____
Date _____