

Adoption Related Services of Pinellas
8800 49th Street N. Suite 212 ♦ Pinellas Park, FL 33782
Fax: (727) 865-5178

MEDICAID PAYMENT AGREEMENT / AUTHORIZATION

CLIENT NAME		DATE OF BIRTH	
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I, the undersigned, a parent and/or legal guardian or authorized representative of the client named above, understand that I am responsible to pay for any therapy services received that are not covered by Medicaid. I further understand that most Medicaid plans do not require any co-payment for therapy services. If there is any co-payment, it will be outlined below. I authorize payment of insurance benefits for therapy service to be made directly to: Adoption Related Services of Pinellas, Inc.

I agree to make every effort to keep all appointments scheduled. If I am late for my appointment, I understand that time might be lost from my session. If I am unable to keep an appointment, I agree to notify my treatment provider at least 24 hours in advance. I understand that missed appointments not cancelled within 24 hours prior to the scheduled appointment can be cause for services to be discontinued. This applies to any and all services received at the agency.

I understand that this authorization will continue to be in effect unless I revoke it in writing.

I will be paying \$ 0 co-payment at each session in accordance with my insurance plan.

Signature of Parent and/or Legal Guardian / Authorized Representative

Date

Signature of Parent and/or Legal Guardian / Authorized Representative

Date

Signature of Parent and/or Legal Guardian / Authorized Representative

Date

Signature of Counselor / Witness

Date