CARLS CENTER FOR CLINICAL CARE AND EDUCATION

1101 Health Professions Building
Mount Pleasant, MI 48859
Phone: (989) 774-3904 (Voice/TTY)
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Audiology Clinics
Speech-Language Pathology Clinics
Physical Therapy Clinics
Psychological Training and Consultation Center

Authorization for Treatment/Assignment of Benefits And Summary Notice of Privacy Practices Acknowledgement

Patient Name: ____ M.R.#:______________

Patient Date of Birth: _________________________________

I hereby authorize payment directly to Central Michigan University (CMU) of any and all benefits for charges for examination and/or treatment received by me or my dependents. I hereby authorize benefit payers to release any and all information requested regarding such benefits and benefit payments to CMU.

I authorize CMU to release of information needed for this claim to my insurance carrier(s).

I will be responsible for any charge that is not covered by any third party payer.

I consent to the performance of medical procedures that are necessary or advisable.

By signing below, I consent to treatment by CMU's Carls Center for Clinical Care and Education clinical staff. I also authorize CMU to use and disclose my information as permitted by the Health Insurance Portability and Accountability Act (HIPAA) and as described in the Carls Center for Clinical Care and Education Notice of Privacy Practices.

Speech-Language Pathology (SLP) Clients:

Given the academic structure of clinical services, CMU SLP services are **not covered** by the Medicare program and will not be billed by CMU. Also, we are NOT enrolled as BCBS providers for speech services; therefore, we are unable to bill BCBS. Payment is the responsibility of the patient.

Psychological Training and Consultation Center (PTCC) Clients:

PTCC is currently not able to bill any insurance (Medicaid, Medicare, BCBS, etc….). Assessment fees are a flat rate, priced according to program type and you are responsible for payment in full. Payment plans may be arranged in case of hardship.

Treatment session fees are based on a discounted sliding scale that takes into account the household income and the number of persons living in the household. You are asked to provide proof of income by your third visit to the PTCC or the fee for your services will revert to the standard fee of $60.00 per hour until you provide proof of income. (After proof of income is provided all fees accrued will be adjusted to reflect the charge based on the sliding fee scale.)

If you are not responsible for payment of fees for the services you are being provided you must (as specified on the following page) provide us with the name of the person, the agency s/he works for, and her/his phone number. In addition you must sign a ***Release of Information*** so that we can set up payment plans with the responsible party.

At your initial appointment with us, we will estimate the cost of services that you will accrue – it will either be a fee per hour for therapy services or a flat fee for assessment services. This remains an estimate until we are provided with proof of income.

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Authorization for Treatment/ Assignment of Benefits (*continued*, Pg. 2:2)	**Patient Name:**			
	MRN:		**Date of Birth:**	

<u>Psychological Training and Consultation Center (PTCC) Clients,</u> *continued*:

- ☐ I am financially responsible for the services being provided at the PTCC
- ☐ I am **<u>not</u>** financially responsible for the services being provided at the PTCC

Name of responsible person: ____________________________________

Agency s/he works for: ____________________________________

Phone Number: ____________________________________

For payment set up, I have referenced the person/agency in the ***Release of Information*** form.

☐ Yes ☐No

I have arranged for or provided documentation from the individual or agency financially responsible for costs relating to my care.

☐ Yes ☐No

<u>Cost for PTCC Services</u>

Based on the Sliding Fee Discount Scale, my fee for therapy services will be **$**__________ per hour.

The estimated cost for my assessment services will be **$**__________.

Client/Parent/Guardian's signature: ____

Printed Name of Above Signature: ____

Relationship to Client: ________________________ Date: _______

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I hereby acknowledge receipt of CMU's Carls Center for Clinical Care and Education ***Notice of Privacy Practices,*** which describes how the Carls Center for Clinical Care and Education may use and disclose my protected health information (PHI).

Client/Parent/Guardian's signature: ____

Printed Name of Above Signature: ____

Relationship to Client: ________________________ Date: _______

For Patients Not Acknowledging Receipt

I hereby certify that the patient did not acknowledge receipt of the Carls Center for Clinical Care and Education ***Notice of Privacy Practices,*** because:

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Signature of Carls Center Staff:____________________________________ Date: _______________