CONFIDENTIALITY STATEMENT

The information that you provide to The CENTER, a Samaritan Center, will be kept confidential. This information will be released to an outside agency or professional only when you sign an "Authorization for Release of Information" form stating that you have full knowledge of the nature of the information that is being released, the purpose for which it is intended to be used, and the name of the qualified person or agency who will receive this information.

The only exception to this would be in those rare occasions when:

1. You are considered to be dangerous to yourself or others.
2. There is known or suspected child abuse that has not been addressed.
3. An order to release code records by a court of law (including subpoena) has been received.
4. A medical emergency.

You hold harmless The CENTER, a Samaritan Center, it's agents and employees, for any loss, costs or damages allegedly sustained by you or your ward because of the release of information under the above listed circumstances.

CONSENT FOR TREATMENT

In order to provide you with mental health treatment, The CENTER, a Samaritan Center, requires your authorization for treatment. By signing below, you or your guardian are indicating that you are agreeing to treatment and authorizing The CENTER therapist and other personnel to provide you with mental health services.

Client(s) or Guardian: _____ Date: _____

Witness: _____ Date: _____

PAYMENT AGREEMENT

Payment is required at the time of service unless previous arrangements have been made. I agree to pay any and all fees, including all legal and collection fees, incurred regarding my account(s).

It is your responsibility to determine if the services requested and providers are covered by your insurance plan. You are responsible for any co-payments, co-insurances, and non covered services as determined by your insurance company. If you lose coverage or change insurance plans, you must notify The CENTER immediately. The CENTER files insurance claims as a courtesy to our clients. In return, we ask that you authorize your insurance company to make payments directly to The CENTER. If you do not wish for The CENTER to file with your insurance, you will be required to pay for services at the time of service.

In signing below, I hereby authorize insurance benefits to be paid directly to The CENTER, a Samaritan Center and understand I am financially responsible for all non-covered charges. I also authorize The CENTER to release to my insurance company any information required to process this claim.

Client(s) or Guardian: _____ Date: _____

Witness: _____ Date: _____