



5815 Broadway • Great Bend, KS 67530
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SIGNATURE FORM

CONSUMER INFORMATION

Last Name:	First Name:	Birth date:	SSN:

PLEASE READ AND INITIAL THE FOLLOWING STATEMENTS BEFORE SIGNING.

- () I have received a copy and understand The Center for Counseling & Consultation's Fee Policy and Client Rights.
- () I have received a copy and understand The Center for Counseling & Consultation's Notice of Information Practices.
- () Assignment of Insurance Benefits: In the event the client/responsible party or the undersigned is entitled to benefits arising out of any insurance policy covering the client, those benefits are hereby assigned to THE CENTER for application toward the clients account. I authorize the release of any medical information necessary to process the claim and request payment of insurance benefits. I understand that I am financially responsible for any charges not covered by insurance.

(IF THIS FORM IS BEING COMPLETED BY A REPRESENTATIVE OF THE CLIENT) PLEASE INITIAL AND PRINT THE NAME OF THE CLIENT RECEIVING SERVICES BELOW.

() I am requesting services for _____

Date	X	Signature of Client/Responsible Party/Guardian
Date	X	Witness