

## MANAGED CARE CONSENT TO TREATMENT FORM

I, \_\_\_\_\_, authorize and request that \_\_\_\_\_, Ph.D., provide psychological examinations, treatment and/or diagnostic procedures pursuant to the policies of the managed care company, \_\_\_\_\_, which now or during the course of my care as a patient are advisable. I understand that the frequency and type of treatment will be decided between me, the managed care company and my therapist. I understand that sometimes managed care companies will only pay for brief treatment which might not be sufficient to meet my needs.

I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement.

I understand that pursuant to the release of information which I have signed, \_\_\_\_\_ Ph.D. will provide specific information regarding my condition and treatment to the managed care company and that \_\_\_\_\_ Ph.D. has no control over how this information might be used.

I understand that I am responsible for payment for any services not paid by the managed care company including charges for missed or cancelled appointments.

I understand that managed care company may determine not to pay for further services. In such a situation, I understand that I may have to decide whether to continue treatment and take responsibility for my own treatment costs.

I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur. I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my therapy as the process can sometimes be uncomfortable.

I have read and fully understand this Managed Care Consent for Treatment Forth.

Date: \_\_\_\_\_ Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Witness: \_\_\_\_\_