FORM MUST BE COMPLETED IF CUSTODY REOUIRES BOTH PARENTS' AND/OR GUARDIANS' PERMISSION FOR TREATMENT

LIFE in BALANCE
COUNSELING & WELLNESS CENTER
Enriching Mind, Body & Spirit

CONSENT FOR TREATMENT OF MINORS

JOINT AUTHORIZATION

Name of Child: _____ **Date of Birth:** _____

We, the undersigned below, authorize treatment deemed necessary by **Life in Balance Counseling & Wellness Center Practitioners.** We authorize **Life in Balance Counseling & Wellness Center** to release to our health plan(s) any and all information which is deemed necessary regarding the care and treatment of our minor child above to ensure prompt payment of all charges for services provided. We hereby assign the payment for all insurance benefits to **Life in Balance Counseling & Wellness Center** for any and all charges incurred in connection with services provided to our minor child. We also consent to a copy of this authorization and assignment being used in place of the original.

We understand fully that we both hereby remain responsible to pay **Life in Balance Counseling & Wellness Center** for all charges not paid by either my insurance company and/or companies, and/or employer, subject to the rules of any Federal or State Health Insurance Program such as Medicaid, or to other contractual provisions that may limit a patient's responsibility to pay for medical costs and services. Payment shall be due at the time of the appointment or within thirty days of receipt of statement.

PLEASE PROVIDE INFORMATION AND SIGNATURES FOR BOTH PARENTS AND/OR GUARDIANS BELOW:

Name: _____ (Please check one): ☐ **Parent** ☐ **Guardian**

Phone Number: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Signature: _____ **Date:** _____

Name: _____ (Please check one): ☐ **Parent** ☐ **Guardian**

Phone Number: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Signature: _____ **Date:** _____