



**Consent To Treat**

Name: \_\_\_\_\_

Please read the following statements carefully and initial.

1. CONSENT TO TREAT:

I give consent for myself and/or family member to receive the necessary evaluation and or treatment by Advantis Therapy, LLC. \_\_\_\_\_

2. RELEASE/REQUEST:

I give permission to Advantis Therapy, LLC to release and/or request information when necessary for the records of the above named individual. \_\_\_\_\_

3. PAYMENT RESPONSIBILITY:

All professional services rendered are charged to the client. Necessary insurance information will be filed for the client. However, the client is ultimately responsible for payment. \_\_\_\_\_

4. INSURANCE AUTHORIZATION/ASSIGNMENT:

I request that payment of authorized benefits be made directly to Advantis Therapy, LLC for any services furnished to me by that provider. I authorize the release of any information to my insurance company required in the course of treatment that may be used to determine benefits payable under my insurance plan. \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date