



### **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