CREATIVE SOLUTIONS
4Kids And Families LLC
A MENTAL HEALTH PRACTICE

Devina Cruickshank Brown, LCSW
Julie Chen, LMHC, CAP

Financial Agreement/Medical Record Release Authorization

Financial Agreement

I UNDERSTAND THAT I AM FINANCIALLY RESPONSBILE FOR ALL CHARGES, CO-PAYMENTS AND DEDUCTIBLES REMAINING AFTER PAYMENTS BY MY INSURERES OR OTHER THIRD PARTY PAYORS AND FOR ALL CHARGES THAT ARE NOT COVERED BY ANY INSURANCE OR THIRD PARTY PAYOR. I ALSO UNDERSAND AND AGREE THAT TO THE EXTENT PERMITTED BY MY INSURANCE CONTRACT OR THIRD PARTY PROGRAM I AM RESPONSIBLE FOR AND WILL PAY ALL CHARGES AND PROGRESSIONAL FEES FOR SERVICES THAT ARE NOT PAID FOR BY MY INSURER OR THIRD PARTY PAYOR BECAUSE THEY HAVE BEEN PROSPECTIVELY DETERMINED TO BE MEDICALLY NECESSARY OR ARE OTHERWISE NOT COVERED BY MY INSURANCE CONTRACT OR THIRD PARTY PAYMENT PROGRAM. I HERBY ASSIGN MY RIGHT TO RECEIVE PAYMENT FOR BENEFITS AND GIVE MY PERMISSION TO EACH OF MY THIRD PARTY PAYORS TO PAY DIRECTLY TO CREATIVE SOLUTIONS 4 KIDS AND FAMILIES LLC, DEVINA CRUICKSHANK, LCSW OR JULIE CHEN, LHMC FOR SERVICE THAT HAVE BEEN RENDERED TO ME. I SPECIFICALLY REQUEST THAT PAYMENT OF ANY BENEFITS PAYABLE TO ME BE PAID TO CREATIVE SOLUTIONS 4 KIDS AND FAMILIES LLC, DEVINA CRUICKSHANK, LCSW OR JULIE CHEN, LHMC. I UNDERSTAND THAT THIS ASSIGNMENT DOES NOT CHANGE OR LESSEN MY RESPONSIBILITY FOR PAYMENT AS DESCRIBED ABOVE.

Name: Signature:
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Date:
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Release of Medical Information

I CONSENT TO AND AUTHORIZE CREATIVE SOLUTIONS 4 KIDS AND FAMILIES LLC, DEVINA CRUICKSHANK, LCSW OR JULIE CHEN, LHMC TO RELEASE IN WRITING OR ELECTRONICALLY TO EACH OF MY THIRD PARTY PAYERS AND HEALTH PROVIDERS MY MEDICAL RECORDS AND INDIVIDUALLY IDENTIFIABLE HEALTH CARE OPERATIONS, PURPOSES INCLUDING THE REVIEW OF PROCESSING OF ANY CLAIMS RELATED TO SERVICES RENDERED TO ME AND I CONSENT TO AND AUTHORIZE MY THIRD PARTIES TO HAVE ACCESS TO , TO USE AND, TO RECEIVE FROM CREATIVE SOLUTIONS 4 KIDS AND FAMILIES LLC, DEVINA CRUICKSHANK, LCSW OR JULIE CHEN, LHMC SUCH RECORDS AND INFORMATION I ACKNOWLDGE AND PERMIT THAT A PHOTOCOPY OF THIS CONSENT AND AUTHORIZATION MAY BE USED IN PLACE THE ORIGINAL THAT I SIGN BELOW:

I UNDERSTAND THAT THIS CONSENT WILL BE VALID FOR ONE (1) YEAR FROM THIS DATE FOR ANY OUTPATIENT SERVICES. I HAVE READ THIS CONSENT FORM CAREFULLY AND HAVE HAD ALL MY QUESTIONS ANSWERED, I UNDERSTAND THIS CONSENT FORM AGREE TO ITS TERMS.

Name: Signature:
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Date:
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