TIFTAREA
PSYCHIATRIC AND COUNSELING SERVICES, LLC
223 East Second Street, Suite B – Post Office Box 1613 – Tifton, Georgia 31793
(229) 339-3721 – www.TiftareaPACS.com – info@tiftareapacs.com

INSURANCE INFORMATION	PRIMARY	SECONDARY
Name of Insurance Company		
Policy Number		
Group Name		
Group Number		
Name of Insured		
Insured D.O. B		
SS# of Insured		
Employer of Insured		

PLEASE READ CAREFULLY

The patient is responsible for All fee, regardless of Insurance Coverage. All charges are due at time of service unless other arrangements have been made in advance. I understand that I am responsible for any amount NOT covered by insurance. I hereby authorize payment directly to Tiftarea Psychiatric and Counseling Services, LLC all insurance benefits not to exceed the Center's regular charges. I hereby authorize Tiftarea Psychiatric and Counseling Services, LLC to release the information needed to any physician and/or third party responsible for payment of such services.

APPOINTMENTS

Schedule, change, and cancel appointments through the office manager. If you find that you cannot keep your appointment, notify our office as soon as possible. A charge of $25 may be made for all appointments not cancelled 24 hours in advance, and this charge will be the responsibility of the patient.

AUTHORIZATIONS FOR TREATMENT/ACKNOWLEDGEMENT OF PATIENT RIGHT

I, the undersigned, hereby request treatment by the staff of Tiftarea Psychiatric and Counseling Services, LLC. I understand that this office does not discriminate on the basis of race, creed, religion, age, sex, political affiliation, physical or mental handicap. I realize that such treatment will be conducted by a treatment team which may include therapists, social workers, psychologists, medical doctors and under appropriate supervision. In addition, I understand that I have rights as a patient and realize procedures exist to file any grievances that may arise during treatment. This authorization will continue in effect until revoked in writing.

Notice of Privacy Practices

This_____ Day of_____20____

_____ _____ _____

(Client/ Legal Guardian's signature) (Date) (Staff Signature/Date)