# *Adult, Child and Family Services, LLC*

**1400 Madison Avenue Suite 610 Mankato, MN 56001 Phone: (507) 387-3777 Fax: (507) 344-1726**

Client Name: ______________________________ DOB: ______________________________

## *RELEASE OF MEDICAL RECORDS*

I hereby authorize any representative of Adult, Child and Family Services, LLC, to release any needed information (including, but not limited to, a summary of my progress in therapy, progress notes, psychological test results, psychological reports) to my insurance company or companies for purposes of receiving authorization and/or payment for services that I receive by this office.

______________________________________________ ____________________
Client's Signature Date

______________________________________________ ____________________
Parent or Guardian's Signature Date

## *ASSIGNMENT OF BENEFITS*

I hereby authorize my insurance carrier(s) to pay any benefits due me under the terms of my policy issued by them. Payment is to be paid directly to Adult, Child and Family Services, LLC, 103 N. Broad St., Mankato, MN 56001.

Payment is authorized upon receipt of an itemized statement and/or claim form for services rendered to me. Indication of my authorization on the billing shall be rendered valid as long as Adult, Child and Family Services, LLC, has this signed Assignment of Benefits in their file.

______________________________________________ ____________________
Client's Signature Date

______________________________________________ ____________________
Parent or Guardian's Signature Date

## *CONSENT FOR TREATMENT*

I voluntarily agree for the above-named client to receive psychological services through Adult, Child and Family Services, LLC which may include diagnostic and treatment procedures provided by my primary clinician or his/her associates.

______________________________________________ ____________________
Client's Signature Date

______________________________________________ ____________________
Parent or Guardian's Signature Date