Please complete and return prior to your first appointment.

Consent to Receive Psychological Examination

I give my consent for LPS Behavioral Health, LLC to perform a psychological examination for me, with subsequent report to my physician upon the physician's request or if required by my insurance carrier.

______________________________________ ____________________

Patient or Authorized Legal Representative Date

Consent to Receive Mental Health Treatment

In the event it is recommended, I give my consent for LPS Behavioral Health, LLC to conduct mental health treatment with me according to a treatment plan developed by Dr. Floyd Robison.

______________________________________ ____________________

Patient or Authorized Legal Representative Date

Consent to Disclose Information to Third-Party Payers

I give my consent for LPS Behavioral Health, LLC to bill Medicare, Medicaid, or a private insurance carrier for services provided me. I also give my consent for LPS Behavioral Health, LLC to disclose to Medicare, Medicaid, or a private insurance carrier information on my evaluation or treatment of that they may require in order to pay a claim for services on my behalf.

______________________________________ ____________________

Patient or Authorized Legal Representative Date

Agreement to Pay Charges

I agree to pay any co-payments required by my insurance carrier for services rendered. I further agree to forward to LPS Behavioral health, LLC any payments from insurance carriers for services rendered that were sent to me.

______________________________________ ____________________

Patient or Authorized Legal Representative Date